

Health Care Financing Grants and Contracts Report

Reimbursement for Durable Medical
Equipment
Vol. I



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Health Care Financing Grants and Contracts Reports

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Health Care Financing Grants and Contracts Report

Reimbursement for Durable Medical Equipment

Volume I (Final Report)

This report was made pursuant to contract No. SSA 600-76-0177 between Health Care Financing Administration and Exotech Research & Analysis Incorporated, Gaithersburg, Maryland.

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FOREWORD

This document is the Final Report of a research and demonstration project entitled "An Experiment in Alternative Methods of Reimbursing for Durable Medical Equipment (DME) Acquired by Medicare Beneficiaries." Under the Congressional mandate of Section 245 of the Social Security Amendments of 1972, the implementation portion of the project was initiated in October 1976. This report describes two different aspects of the DME portion of Medicare: first, the implementation, operation and results of the experiment are considered; and, second the collection, tabulation and interpretation of a large database of DME claims is presented. Prior to this report, no effort of this magnitude had been undertaken with respect to DME.

Volume I provides a chronology of the events which took place during the implementation of the experiment. This chronology includes background information on the legislative, administrative and research history pertaining to DME as well as a full description and explanation of the experimental alternatives which were utilized. Specific details of the reimbursement mechanisms are included in the discussion. The Medicare reimbursement process as it pertains to DME is also described including: the reasonable charge process, the payment process and a general interpretation of the assignment provisions of Medicare as they relate to DME. The findings section includes information on the following topics: DME use by Medicare beneficiaries, characteristics of the claims flow; reimbursement by monetary class intervals; amounts paid for rental and purchase of DME; rental versus purchase reimbursement; estimates of annual reimbursement for DME; duration of rentals; cost of extended rentals; administrative costs; and details of the data derived from the experimental area. The concluding section of Volume I details implications of the research and demonstration project and provides considerations for the Health Care Financing Administration.

Volume II of the Final Report contains Appendices which present data, information and statistics derived from a large set of DME claims tabulated by the contractor. These Appendices (labeled A - N) describe expenditures and reimbursement for DME, administrative and programmatic statistics relating to DME and legal issues regarding the use of the reimbursement alternatives tested in the experiment.

ACKNOWLEDGEMENTS

This research and demonstration project was conducted under the direction of Libert Ehrman and Theodore J. Janssen. The final project staff at Exotech Research & Analysis, Inc. included: J. Michael Talbot, Programmer/Analyst; and, Carla J. Riley, Administrative Assistant. Others of the staff of Exotech contributed to the project over the three years of its duration and all deserve the thanks of the author.

The project team wishes to express its appreciation for the cooperation, assistance and receptivity on the part of all those who participated with us in this project. This is particularly true of the Part B carrier management and staff personnel who provided the means by which this project could be undertaken. Specifically, we wish to thank the Equitable Life Assurance Society of the United States, Group Health Incorporated, Occidental Life of California, The Travelers Insurance Company and the Washington Physicians Service. Within the carrier organization in Washington, all of the county bureaus are to be noted for actually implementing and operating the experiment. Both the Medical Service Bureau of Spokane County and the King County Medical Blue Shield organizations deserve particular note for their activities in support of the experiment. In addition, the substantial support of the Seattle Regional Office throughout the project is also acknowledged. Special thanks from the author is made to Clayton Field, Vice President of the King County Medical Blue Shield organization for his support and direction throughout the project.

The assistance and cooperation of other carrier, intermediary and Medicaid state officials should also be acknowledged. Although others may not have decided to participate in the experiment, their assistance to the project team in providing an overall understanding of the complex web of relationships between various health insurance programs in the United States proved invaluable.

The assistance and effort of the Advisory Panel convened for the project also should be mentioned. Seasoned professionals representing the various participants in the DME chain from physician to supplier to beneficiary to insurer provided a knowledge of the need and use of DME that added a dimension of reality to a program that often lacks human considerations. The concerns of these Advisors reflected their experience and relationship with the health care industry in a way that was most useful to the project team.

The contributions of G. Theodore Saffran, the HCFA Project Officer for this project, have been substantial. Mr. Saffran not only monitored project activities from the perspective of his own interest in the subject and the need to perform such efforts, but also served as a staff resource to the entire project through his operational contributions, the provision of data and information, his constructive review of project documents and, not to be left unsaid, his companionship while traveling. The entire project team is most appreciative of his efforts in seeing this project through to its successful completion.

Within the HCFA Central Office and Regional Offices, many other individuals and organizational entities should be mentioned for their interaction with the project. Unfortunately, space does not allow such mention. Although not always supportive of the efforts being undertaken, their inputs to the project team were given considerable attention and project plans were often altered based on these considerations.

CHAPTER I

SUMMARY

PURPOSE OF THE STUDY

The study was designed to fulfill the legislative mandate of Section 245 of the Social Security Amendments of 1972, P.L. 92-603. The mandate called for the conduct of reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment with respect to the Medicare program.

AIMS, METHODOLOGY AND LIMITATIONS

Under contract to the Office of Demonstrations and Evaluations, Office of Research, Demonstrations and Statistics, of the Health Care Financing Administration, Exotech Research & Analysis, Inc. (ER&A) has undertaken the implementation of an experiment in alternative methods of reimbursing for durable medical equipment (DME) acquired by Medicare Part B beneficiaries. As part of the study, ER&A conducted site visits to nineteen Part B carriers covering parts or all of thirty-seven states to solicit their cooperation in the project. Five carriers agreed to participate. They were: The Equitable Life Assurance Society

of the U.S., Group Health Incorporated, Occidental Life of California, The Travelers Insurance Company and Washington Physicians Service. These carriers operate the Part B program in all or parts of eleven states.

HIGHLIGHTS FROM THE FINDINGS

Estimates have been made for the cost of reimbursement by the Federal Government for DME based on data furnished by the carriers. For calendar year 1976, these estimates range from \$50 million to \$134 million, and for 1977 they range from \$73 million to \$130 million. Single point estimates of these costs are \$72 million and \$89 million respectively. Rental reimbursement for 1976 accounted for 53% of the total with purchases accounting for 47%. Rental reimbursement for 1977 accounted for 40% of the total with purchases accounting for 60%.

Oxygen, oxygen therapy equipment and related items accounted for nearly half of the total reimbursement dollars with hospital beds, wheelchairs and associated accessories accounting for another third. A greater percentage of reimbursement dollars is spent on the rental of equipment relative to its purchase because the purchase of oxygen makes up nearly half the total of purchases.

Based on the data collected, the average duration of a rental episode ranges from roughly 3 to 5 months with an overall average duration of just more than 4 months. While this period may seem relatively short, the data show that substantial numbers of monthly reimbursements are associated with a small

fraction of rentals which are for an extended period. Analysis shows that rentals of more than a year's duration accounted for approximately 15% of total rental reimbursement. If the definition of extended rental is taken to be those which continue for a year or more, then some \$12 million annually is estimated to have been spent during 1976 - 1977 on these rentals. It should be pointed out, however, that not all of this amount is available for savings to the program as certainty concerning the medical necessity of the beneficiary does not exist at the time the DME is prescribed.

Various descriptive statistics concerning aspects of the Part B program were determined during the course of the project. One was the ratio of DME users to enrolled beneficiaries. The percentage of DME users out of enrolled beneficiaries was calculated to be 11%. Another aspect of the program concerned the assignment of claims. Tabulations showed that rental assignment were larger than assignment for purchase claims, particularly when assignments for oxygen were excluded. Difficulties with the passage of title and differing state laws seem to have a negative effect on the assignment program as it relates to DME. In addition, charge levels are also thought to hinder acceptance of assignment.

Data analyzed from the Beneficiary History Files provide useful information on the flow of claims and associated payments by the Part B program. Upon considering the totality of claims or requests for payment for DME, it was determined that 14% of the line items are denied, presumably because of ineligibility of the beneficiary or non-coverage of the equipment. Of the remaining 86%, payment determinations are made. Nine percent of the total

never receive payment because the deductible has not been met and the remaining deductible is greater than the allowed charge for the claim. Seventy-seven percent of the claimed line items result in payment, although some deductible could have been applied in these cases also.

If consideration is given to the submitted charges of claims which are not subsequently denied, then it can be seen that the Part B program pays 60% of the charges; reasonable charge reductions account for 18%; deductible payments account for 7%; and , co-insurance payments account for the remaining 15% of the total.

For rentals, some 99% of the line items and 92% of the associated reimbursement payments were \$100 or less. Conversely, only 1% of the line items for rental were ever reimbursed more than \$100. For purchases, 97% of the line items and 73% of the associated reimbursement payments were \$100 or less. Thus, 3% of the line items and 27% of the total reimbursement for purchase was in excess of \$100. Of note was some 6% of the total reimbursement for purchase made in payments greater than \$450.

THE REIMBURSEMENT EXPERIMENT

The experiment, carried out in the state of Washington by the Washington Physicians Service and its subcontractors was intended to develop and implement reimbursement procedures as alternatives to the regular procedures with respect to the reduction of program costs due to extended rentals. Results from the

experiment indicate that purchases increased and the proportion of reimbursement expenditures for purchases which was, in fact made up of equipment, grew. Consultation with the carrier indicated a reduction in the number of monthly installment purchase reimbursements and processing operations. Inclusions of used equipment alternatives with certain incentives did not stimulate purchases nor did rental/purchase alternatives. The lump-sum provisions, however, seem to have allowed for more purchases of needed equipment that was relatively expensive but for which purchase was justified by the prescribing physician's estimate of the length of medical need for the item.

CHAPTER II

CHRONOLOGY

LEGISLATIVE, ADMINISTRATIVE AND RESEARCH HISTORY

The original Medicare law (the Social Security Amendments of 1965, 79 Stat. 286) provided for reimbursement for durable medical equipment (DME) to beneficiaries of the Supplementary Medical Insurance portion (SMI) of Medicare called Part B. DME was defined as equipment which:

- a) can withstand repeated use;
- b) is primarily and customarily used to serve a medical purpose and,
- c) generally is not useful to a person in the absence of an illness or injury; and,
- d) is appropriate for use in the home.

Traditional examples of DME include: wheelchairs, hospital beds, canes, commodes, crutches, walkers, oxygen therapy equipment and the like. This law provided for reimbursement only in the instance that the beneficiary had rented the equipment.

In the Social Security Amendments of 1967 (81 Stat. 821) the Medicare law was changed to allow for reimbursement for either rental or purchase. Expenses incurred by a beneficiary for the rental or purchase of DME were reimbursable if the following three requirements were met:

- a) the equipment meets the definition of DME; and,

- b) the equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his malformed body member; and,
- c) the equipment is used in the patient's home.

The freedom of choice provisions of Section 1802 of the Social Security Act (42 U.S.C. 1395a) allowed a beneficiary to determine whether he would purchase or rent. Freedom of choice was also considered to be the intent of the 1967 Amendments. The Senate Finance Committee Report on House Bill No. 12080 (Sen. Rep. No. 744, 90th Congress, 1st Session, 1967) explains the 1967 Amendments pertaining to DME as follows:

"The committee's bill would make benefits covering durable medical equipment more responsive to the needs of the patient by including a provision which would permit medical insurance benefits to be paid in situations where an individual chooses to purchase rather than to rent the equipment. However, this provision would operate only as an economical alternative to the present coverage. To avoid paying the full purchase price of costly equipment used only a short time and, thereby, allowing the patient or his estate to profit upon its disposition, the bill would provide that benefits for the purchase of relatively expensive items of durable medical equipment would be paid in monthly installments that are equivalent to the payments that would have been made had the patient chosen to rent the equipment. Moreover, benefits would be paid only for that period of time during which the equipment was certified to be medically necessary or until the purchase price of the equipment had been fully reimbursed, whichever came first. The patient would wish to make the purchase under these circumstances if the purchase was less costly than rental because through the purchase his coinsurance payments would be reduced.

With respect to the purchase of inexpensive equipment, on the other hand, the committee's bill would permit a lump-sum payment of benefits where the carrier determines a single payment to be more practical than periodic payments."

Because of the expressed interest of the cognizant legislative committees of the Congress, the General Accounting Office (GAO) made a review in five states (California, Illinois, Michigan, Washington, and Wisconsin) to see if the current Medicare law was promoting the most economical ways of providing DME used by Medicare patients in their home. In May 1972, the Comptroller General of the United States submitted a Report to the Congress entitled "Need For Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare" which concluded that the current Medicare law was not necessarily the most economical way of providing DME. It was found that Medicare patients often rented DME for prolonged periods of time even though purchase of the DME might have been justified by the period of need estimated by the patient's physician. This finding led to the conclusion that savings could be effected if the extensively long rentals could be decreased or eliminated.¹

In addition to this major GAO finding, secondary findings included the following:

- a) A variety of factors led patients to rent equipment even though their physicians had indicated long-term needs, for the following reasons: equipment suppliers would not accept patients' assignments of their rights to reimbursement for purchase because Medicare could discontinue payments; patients had to rent equipment because they could not afford to make initial payments which were reimbursable by Medicare only through installments; patients had little incentive to reduce costs by purchasing equipment because their co-insurance share of the rental charges was paid by others or forgiven by suppliers; and patients were unaware of their option to purchase.

¹ The question of whether long-term need is apparent at the outset of a DME episode and whether the beneficiary is able to make the initial payments are discussed later.

- b) Medicare restrictions on purchases were incompatible with Medicaid provisions, resulting in the encouragement of long-term rentals by patients enrolled in both the Medicare and Medicaid.
- c) Equipment prices under Medicare were higher than prices under other Federally financed health programs, for example, equipment purchased by the Veterans Administration (VA), the Public Health Service (PHS) and some State Medicaid agencies was procured on the basis of competitive bids at discounted prices, often considerably less than the suppliers' prices which were the basis for charges to Medicare .

In a section of the Report entitled "Recommendations or Suggestions," the GAO stated:

" . . . the best solution to this problem may differ from area to area, depending on such factors as the provisions of the State Medicaid programs and the practices of the suppliers. Therefore GAO believes that HEW should have flexibility in finding the best solution in a given locality. The Congress should amend the Medicare law to authorize HEW to find more economical methods of paying for durable medical equipment, including authority to:

--Make lump-sum payments for purchases of equipment when, on the basis of anticipated periods of need, purchase appears to be more economical than rental; require the early submission of such claims; and limit payments to the amounts payable under the recommended rent-or-purchase decision.

--Enter into agreements with suppliers aimed at limiting rental payments after they exceed the purchase prices by specified percentages and at obtaining prices for the purchase of equipment that are comparable to those obtained by other Federally financed health programs.

HEW was given an opportunity to review a draft of this report and agreed with GAO's recommendations. Further, on March 17, 1972, the Senate Committee on Finance announced that, in con-

nection with the committee's deliberations on the Social Security Amendments of 1971 (H.R. 1), it had decided to initiate an amendment to the Medicare law . . . which would authorize the Secretary of HEW to test and implement, without further legislation, reimbursement approaches designed to eliminate unreasonable expenses to the program which had resulted from prolonged rentals of durable medical equipment. This proposed amendment would include authority for the Secretary of HEW to contract with suppliers of equipment and to make lump-sum payments for durable medical equipment when the carrier determines, in accordance with guidelines from the Secretary, that outright purchase probably would be more economical than rental."

On October 30, 1972, the Congress enacted the Social Security Amendments of 1972 (P.L. 92-603). Section 245 authorized the Secretary of the DHEW to experiment in various geographic areas with reimbursement approaches that are intended to prevent unreasonable expenses from prolonged rentals of DME .

Section 245 reads:

PAYMENT FOR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE

Sec. 245. (a) The Secretary is authorized to conduct reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment described in section 1861 (s) (6) of the Social Security Act.

42 USC 1395x

79 Stat. 302.
42 USC 1395l.

(b) Such experiments may be conducted in one or more areas, as the Secretary deems appropriate, and may, pursuant to agreements with suppliers, provide for reimbursement for such equipment on a lump-sum basis whenever it is determined (in accordance with guidelines established by the Secretary) that a lump-sum payment would be more economical than the anticipated period of rental payments. Such experiments may also provide for incentives to beneficiaries (including waiver of the 20 percent coinsurance amount applicable under section 1833 of the Social Security Act) to purchase used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for new equipment.

(c) The Secretary is authorized, at such time as he deems appropriate, to implement on a nationwide basis any such reimbursement procedures which he finds to be workable, desirable, and economical and which are consistent with the purpose of this section.

81 Stat. 850. (d) Section 1833 (f) of the Social Security Act is amended —

(1) by striking out "with respect to purchase of inexpensive (as determined by the Secretary)" and inserting in lieu thereof "(A)", and

(2) by inserting before the period at the end thereof the following: ", and (B) with respect to purchases of used equipment the Secretary is authorized to waive the 20 percent coinsurance amount applicable under section (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment."

(3) by inserting "(1)" after "(f)" and by adding after paragraph (1) the following new paragraph:

"(2) In the case of rental of durable medical equipment, the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump-sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible."

The first stage in these reimbursement experiments were three competitively bid contracts awarded in June, 1974 by the Bureau of Health Insurance, Program Experimentation Branch of the SSA. These projects undertook the development of three different Protocols for the operation of reimbursement experiments as Phase I of a dual-phased project. The primary objective of these projects was to develop protocols to establish and support changes in reimbursement procedures and to make recommendations to the Secretary of the DHEW. After a review of these protocols by the SSA, the decision was made to modify one of them and to implement only that design as an experiment.

The Congress has shown a continuing interest in Federal reimbursement for DME. On May 17, 1976, Congress focused specific attention on the requirements given to the DHEW to perform research on the Medicare and health cost-saving experiments. On that day, Representative Richard F. VanderVeen, chairing the

Oversight Subcommittee of the House Ways and Means Committee, reiterated the belief of the Congress that "these experiments may hold the key to urgently needed improvements in cost control and quality in Federal health care programs." During the hearing, testimony was entered by the GAO which essentially summarized their view of the DME prolonged-rental problem. Commissioner Cardwell of the SSA also submitted testimony summarizing the research efforts of the protocol development period that had been made concerning DME. His comments noted that a Request for Proposals (RFP) to implement the revised protocol had been issued.

As a result of competitive bidding, the contractor who had been responsible for the development of the Protocol design was awarded a three-year contract to implement the DME experiment with an effective starting date of October 15, 1976. Administration of the project by the Government was the responsibility of the Program Experimentation Branch which had been moved to the Division of Health Insurance Studies, Office of Research and Statistics, SSA. In the Spring of 1977, DHEW reorganization resulted in the project being administered at the federal level by the Office of Demonstrations and Evaluations, Office of Policy, Planning and Research of the newly formed Health Care Financing Administration (HCFA). Further reorganization placed final responsibility for the project in the Office of Demonstrations and Evaluations, Office of Research, Demonstrations and Statistics of the HCFA.

THE EXPERIMENTAL PROJECT

Preparation of the Proposal

Introduction

According to the General Instructions of the Social Security Administration Request for Proposals Number 76 - 0373:

"The purpose of this Request for Proposals (RFP) is to solicit proposals for conducting an experiment in alternative methods of reimbursing for durable medical equipment (DME) acquired by Medicare beneficiaries. The experiment's primary objective is to test procedures which are intended to eliminate unnecessary expenditures resulting from prolonged rentals of DME and to provide a basis to determine if the experimental methodology is more workable, economical, and desirable. These methods, if proved successful, may become the basis for the general adoption of these methods into the Medicare Program."

Solicitation of Carriers

In the Summer of 1976, during preparation of a proposal in response to the RFP cited above, Exotech Research & Analysis, Inc. (ER&A) reestablished contact with those Medicare Part B carriers with whom a relationship had been established during the protocol development period. The purpose of this effort was to solicit their cooperation in taking part in the DME experiment as evidence that the offeror had commitments from Part B carriers identifying participative intent was a requirement of the RFP.

During the protocol development period ER&A had visited the following Part B carriers to discuss their participation in the experiment:

Blue Shield of California

Blue Shield of Florida, Inc.

Group Medical and Surgical Service (Texas)

Kansas Blue Shield

Metropolitan Life Insurance Company

The Travelers Insurance Company

At the end of the protocol period, one and one-half years earlier, several of these carriers had agreed to participate unconditionally, while others indicated a willingness to negotiate participation based on receiving detailed specifications of the protocol for the experiment. Carrier participation was based largely on the extent to which the experiment would disrupt the existing system of operations.

Upon inquiring of these carriers whether they might still be willing to cooperate in the DME experiment, two chose not to participate in the implementation phase. Alternative carriers were solicited so that the RFP requirement for "at least three and not more than six Part B carriers" would be met. In addition, the carrier participation requirements of the RFP also specified that "at least three and not more than eight geographic areas" must be covered.

With a view toward national implementation, it was deemed necessary that experimentation be done in various geographic locations so that regional differences in response to the experiment could be ascertained. It was known that differences in state laws with regard to Medicaid and its influence on payment of the beneficiaries' co-insurance and deductible existed. Also, state laws and commercial codes differ as to their provisions for the passage of title from one

party to another. Further, price structure and equipment usage patterns were thought to differ between the states. Also, differing socio-economic characteristics of the beneficiaries were assumed to influence the rent or purchase decision process and it was considered conceivable that these characteristics were of a regional nature.

Exotech Research & Analysis, Inc. sought to achieve a combination of carriers of various types and in various locations so as to make the experiment as free of bias from single-type or single-region characteristics as possible. During preparation of the proposal, it became clear that a rigorous statistical sampling approach for including carriers would not accomodate the situation that was encountered when an attempt to enlist carrier participation on a voluntary basis (as specified in the RFP) was undertaken.

There was concern, of course, with obtaining a distribution of carrier service areas that would provide representation of broad geographic population areas. Consequently, SSA Regional Offices and a large number of carriers were contacted. However, it was found at this preliminary stage that the following had to be ruled out of consideration: Arizona, Oklahoma, Hawaii, Alaska, Maryland, Nevada, Oregon, parts of New York City, New Jersey, Massachusetts, Pennsylvania, Florida, Texas, California, and Ohio. Some carriers were excluded by the Regional Offices, without specific mention, but by means of generalized reference to their regions. In some instances, ER&A contacted more than one carrier in a state, where responsibility for parts of a state was split. In one case, a number of states had to be excluded since all represented operations by a single carrier.

Despite the above, geographic dispersion and a variety of types of carriers was obtained. With respect to type of carrier, initial cooperation was obtained with the following types: private carriers, Blue Shield plans, single state, multi-state and one carrier, unique in the nation, that operated through a multiple county bureau structure.

After considerable effort, ER&A was able to secure letters of intent for participation from:

Kansas Blue Shield

Metropolitan Life Insurance Company

The Travelers Insurance Company

Washington Physicians Service

These carriers administered Medicare Part B in all or parts of Kansas, Mississippi, Minnesota, New York, Virginia, and Washington.

Assembling the Advisory Panel

As the implications of this project were extremely broad and the experiment intended to lead to revision of reimbursement methods for DME, Exotech Research & Analysis, Inc. believed it essential that the project and SSA should have the benefit of both expert advice in carrying out the various aspects of the experiment and of the views of the major segments of the hierarchy of organizations whose constituents participate in DME decision-making. For this reason, ER&A proposed a high level Advisory Panel for the experiment. Concurrence to furnish a member who would serve on the Advisory Panel was obtained from the organizations listed below:

Abbey Rents and Sells

American Association of Retired Persons

American Medical Association

American Rental Association

Delcrest Medical Products, Inc.

National Affiliation of Durable Medical Equipment Companies

National Association of Blue Shield Plans

Rental Services Association

As the implementation of the experiment hinged on the cooperation of suppliers of DME, carriers, the medical profession and Medicare beneficiaries, all of these groups were represented on the Advisory Panel. Additionally, advice would be obtained from all the carriers in the geographic areas in which the experiment was to be carried out. An initial meeting of the Advisory Panel was scheduled near the beginning of the proposed effort for the purpose of soliciting comments on the methods which were intended to be followed in preparing for and carrying out the experimental activities. Subsequent meetings were proposed at intervals thought to be appropriate for the timely review of implementation. A final meeting was proposed toward the end of the project for the purpose of reviewing a draft of the data and analysis prepared by ER&A. The views of the Advisory Panel on the draft report were to be used in preparation of the Final Report submitted to the Government.

Additionally, the members of the Advisory Panel were to serve as resource persons to help resolve matters or to provide assistance where their specific

inputs would be helpful throughout the course of the project. The SSA was requested to arrange for the participation of the Project Officer as an ex-officio member of the Advisory Panel.

Consultants

To supplement the skills and activities of the ER&A staff, a plan was proposed to use consultants for specialized activities. In general, members of the Advisory Panel were to provide advice and counsel at regular meetings. In addition, certain members of the Advisory Panel were to provide services to ER&A beyond the periods normally required for the meetings. Two members of the Advisory Panel in particular, representing suppliers, were proposed as Consultants to the project. Both of these persons had upwards of thirty years of experience in the rental and sales business and had held leadership positions in their respective national associations of DME suppliers.

The requirement for legal assistance was also recognized. One example of this need was the development of model contracts which were appropriate to the reimbursement alternatives of the experiment. An attorney was needed to draw up these agreements, taking into account state laws and precedents as well as general legal practice for such contracts. This effort was assumed to require legal research into the laws and precedents for each of the selected areas in which the experiment was to take place so that the instrument which was finally adopted would have all the necessary and required elements.

Anticipating the possible short-term need for a writer who had extensive institutional advertising experience, a Consultant with skills in journalism, public

relations and public affairs, largely for non-profit and U.S. Government organizations, was proposed.

The Alternative Reimbursement Procedures

As stated in the RFP:

" . . .

5. The experiment contemplated shall test the following reimbursement mechanisms for DME approved as medically necessary by the Part B carrier and presently covered under Medicare Part B (Supplementary Medical Insurance):

- a. Lump-sum reimbursement, based on the anticipated period of need, for the purchase of new equipment (LSN);
- b. Lump-sum reimbursement, based on the anticipated period of need, for the purchase of used equipment (LSU); including waiver of the coinsurance when the purchase price is at least 25 percent less than the reasonable charge for the new equipment; and
- c. Delayed lump-sum reimbursement (rental-purchase conversion procedure) for the purchase of new (DLSN) or used (DLSU) equipment including rental reimbursement for the period of rental and a lump-sum reimbursement for purchase, based on the anticipated period of medical need, when the conversion occurs. Rental reimbursement is subject to the present Medicare Part B procedures. Delayed lump-sum reimbursement shall be subject to the following:
 - (1) Rental-purchase conversions occurring during the first six (6) months of rental shall have at least one month's rental fee deducted from the reasonable charge for purchase;
 - (2) Rental-purchase conversions occurring during the seventh (7th) month and thereafter shall be discounted in accordance with the following procedure:

At least a 2% per month discount (cumulative with the reduction specified in paragraph 5 c (1) (above) for each month beginning with the seventh (7th) month of rental shall be deducted from the reasonable purchase determination (that specified at the outset of rental by the carrier). The discount shall be continued cumulative until such time as a total of at least a 66 2/3% reduction of the original reasonable purchase price determination is reached, dependent upon the reasonable monthly rental charge and monthly reduction applied.

Note: There is no change in present procedures for rental reimbursement."

Any reimbursement procedure for DME must meet legal and economic tests before it can be considered as a procedure to be implemented in an experiment or for that matter, nationally. Three criteria considered important in this respect were the following:

- a) Beneficiaries must have the freedom of choice in acquiring DME, by rental or purchase, regardless of supplier:
- b) Provision for the needed DME as long as medical necessity exists; and
- c) Potential to perform successfully in the marketplace.

The beneficiary who had a long-term medical need must be given the opportunity to select between rental or purchase of DME. It is true that the beneficiary probably should not purchase if the medical need is not long-term, as such purchases are not economically justified. However, the argument, that if long-term medical need has been established the beneficiary would only be allowed to purchase DME was also obviated by these criteria. For this experiment the freedom of choice provision of the Medicare law and the SSA philosophy of voluntary experimentation was to apply, and the rent or purchase decision was left to the beneficiary.

The provisions for DME must be commensurate with the duration of a bonafide medical necessity. Any payment mechanism must be designed so that a beneficiary is not terminated or denied services or reimbursement from Medicare while medical necessity exists. Such mechanisms are not the intent of the law and its implementation.

If a maximum limit is placed on payment for rentals without provision for transfer of title and medical necessity still exists, then the beneficiaries have only the following courses of action:

1. Continue to rent, paying total cost of rental;
2. Purchase item of DME assuming the risk of not being reimbursed by Medicare;
3. Purchase a private health insurance plan;
4. File a new claim with the same or another supplier after obtaining a new prescription;
5. Apply to Medicaid for assistance; or
6. Do without.

Rental payment limitations, as a solution to the problem of prolonged rentals, were not considered the intent of the Medicare law which was ". . . enacted as a Federal indemnity insurance program to provide beneficiaries protection against costs incurred for covered health service."²

The payment procedures must be such that the providers of DME are willing to offer DME goods and services and the beneficiary and Government are willing to pay. In short, a voluntary market transaction is made. Neither can the reimbursement procedure be designed to pass title of an item of DME from one party to a second party automatically and involuntarily. The success of a DME reimbursement procedure in the market can be measured both by its acceptance commercially and utilization by beneficiaries. The assignment process might also be considered a reflection of the popularity of an alternative reimbursement mechanism.

² Memorandum, DHEW Office of the General Counsel, Appendix I, December 30, 1971: Contained in the "Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare," GAO Report B-164031 (4), May 12, 1972.

Other Requirements and Issues

Again, according to the RFP, the following requirements were included and issues raised in the Scope of Work.

"4. Hemodialysis equipment and supplies shall be excluded from this experimental effort. All other durable medical equipment items, as covered under Medicare Part B, shall be included in this project.

. . .

6. Suppliers shall voluntarily agree to participate with the Government and the carriers in these experimental reimbursement procedures and, for the rental-purchase conversion procedure, shall agree to discount their actual selling prices for DME with a corresponding discounting procedure as outlined in paragraph 5 c above; i.e.

a. Rental-purchase conversions occurring during the first six (6) months of rental shall have at least one month's actual rental fee deducted from the the original selling price (that established at the outset of rental);

b. Rental-purchase conversions occurring during the seventh (7th) month and thereafter shall be discounted in accordance with the following procedure: At least a 2% per month discount (cumulative with the reduction specified in paragraph 6 a) for each month beginning with the seventh (7th) month of rental shall be deducted from the original purchase price. The discount shall be continued cumulative until such time as a total of at least a 66 2/3% reduction of the original purchase price is reached, dependent upon the monthly rental charge and monthly reduction applied.

7. Part B carriers shall voluntarily agree to participate for the duration of this experimental effort.

8. The purchase, property management, acquisition, storage, maintenance and/or distribution of any or all DME utilized for the study to be conducted hereunder shall not be contemplated by the Government.

9. The "Freedom of Choice" provision of Title XVIII for Medicare beneficiaries shall not be waived.

10. The present procedures utilized by Part B carriers in establishing and administering reasonable charge screens shall remain in effect.

11. The assignment provisions of Title XVIII shall remain in effect during the experiment unless specifically waived.

12. The critical issues under this experiment include, but are not limited to: the quality of the reimbursement mechanisms; characteristics of the study population; impact on access to DME by beneficiaries; supplier, carrier, and physician participation; savings realized by the Medicare Program; beneficiary incentives for economical purchase; market workability with suppliers; and feasibility for national implementation.

13. Except as otherwise stated, all current Medicare Part B regulations and procedures apply."

All of the requirements stated above were taken into consideration or included in the project as proposed by ER&A. Of major operational consideration was the open-endedness required of the experiment by law and the SSA philosophy of experimentation. It was unrealistic to assume that any group of beneficiaries or suppliers could be forced to participate in an experiment. Therefore, any type of blocked experiment would prove to be either impractical, unfeasible or illegal. In conjunction with the unavailability of data concerning the magnitude of the program and the prolonged rental problem and the RFP requirement for voluntary participation by carriers as well as suppliers and beneficiaries it was necessary to design an experiment that provided incentives for cooperation that were economically attractive and justifiable.

An understanding of the economics of the supplier industry was considered particularly important in devising workable and acceptable payment alternatives. The economics of rentals and purchases have two different bases. Rental is based on the costs for providing temporary use of equipment and related services. Purchase is based on the costs of transferring equity from one party to another. A rental/purchase conversion is a hybrid which provides for a contractual means of converting a rental agreement to a sales contract and, therefore, must satisfy the economics of rental and purchase because both are involved.

Considerable misunderstanding of the term rental/purchase option or conversion, lease-purchase option, and installment purchase plan exists. The latter two provide for a deferred sale where the total cost of transferring equity is divided into a series of payments and the purchaser is committed for the entire amount. A rental/purchase option or conversion must consider the rental and purchase separately. It must be understood that rental does not involve the transfer of equity but is a method for providing temporary use of equipment. Rental rates, therefore, are a function of providing this temporary use and its associated services. In contrast, purchases reflect the costs of transferring equity be there one payment or many.

An item of rental equipment is a working asset owned by the renter for the sole purpose of earning income for the owner. By traditional practice, rental items are not part of an inventory for sale. The dollar value of a rental item is its potential future earning power from the market place. For example, assume an item whose retail price is \$100, rents for \$10 per month and has a five year serviceable lifetime. Its potential rental income value is \$600 to its owner when the item becomes a rental asset. Further, assume that the item is rented to one person for the entire first year and the rentee has paid \$120 to the owner. At the beginning of the second year its worth to the owner is the replacement cost of the asset which would continue the owner's capability to do the same level of business. The point is that purchasing an item out of rental assets does not provide a method for dealing with depreciated equipment at appropriate reduced prices.

An extremely serious problem at the time, whose rectification was thought to be fundamental to the success of the experiment, was that prices allowed for DME under Medicare were much less than market prices. Since allowed charges are based on submitted charges from a previous calendar year, they are always between six and eighteen months lagging current market prices. In periods of economic stability these historical prices should approximate current market prices. However, price controls, imposed earlier in the decade, and the accelerating inflation which had occurred since they were lifted resulted in allowed charges that, according to suppliers, did not reflect current market prices which had as their base current market costs. The result was that DME providers indicated that they were abandoning the assignment program of Medicare, particularly with respect to sales. To help insure the success of the experiment, ER&A suggested that the price screens of the Part B carriers be updated so that allowable charges would reflect current market prices. As noted in the RFP, however, the experiment was unable to affect the establishment or administration of the reasonable charge screen.

Finally, under Medicare Part B procedures which were applicable in 1976, if the beneficiary elected to purchase, there were two methods of reimbursement for DME. Payment for purchase of inexpensive equipment, items for which the allowed charge was \$50 or less, were made in a lump-sum, subject to the deductible (where applicable) and co-insurance. Items for which the allowed charge for purchase exceeded \$50 required that reimbursement benefits be paid in monthly installments equivalent to the payment that would have been made had the equipment been rented. These payments were restricted to the established

period of medical necessity or until the program's share of the allowable purchase price had been paid, whichever first occurred. Payment in either case could be made directly to the beneficiary or assigned to the supplier of DME, provided that the total charges for the equipment did not exceed the allowed charges as determined by the carrier.

Where payment was made for the rental of DME, monthly benefits continued for as long as the medical necessity existed. Payment could be made directly to the beneficiary or assigned to the supplier of DME, provided that the total charges for the equipment did not exceed the allowed charges as determined by the carrier.

Under these procedures also, the Medicare benefit payment amount was 80% of the allowed charges for covered services after the annual deductible of \$60 had been met by the beneficiary. The remaining 20% co-insurance amount was the responsibility of the beneficiary and was either borne by him/her or paid, in total or in part, by another insurance plan (e.g., Medicaid, private insurance, etc.). After establishing the medical necessity for use of the DME, the allowed charge was determined by each Part B carrier by comparing the customary charge (that made by an individual supplier) and the prevailing charge (that made by suppliers in the same locality) and the lesser amount is used for computing payment.

The preceding paragraphs have outlined the basic structure of Medicare Part B reimbursement for DME. It was these concepts of reimbursement which the Congress and the Administration sought to change through implementation of the Experiment.

Implementation of the Project

Introduction

Exotech Research & Analysis, Inc. was awarded the contract to implement the DME reimbursement experiment described herein with an effective date of October 15, 1976. The contract was divided into phases which covered a three-year period. The first, of nine months duration, was the Start-Up phase. Activities during this period were designed to prepare all parties who would be involved in the implementation of the alternative reimbursement procedures. The second phase, of twenty-four months duration, was the Reimbursement phase in which monitoring of the experiment and data collection was to be undertaken. The Final phase included three months for the preparation of the Final Report encompassing the entire study.

The following section provides a chronology of events covering the entire project. Essentially it is a narrative description of all important project activities.

The Narrative Chronology

October, November 1976

Activity during this period took the form of meetings with carriers, the Social Security Administration, one supplier group and one of the supplier consultants retained for the project.

In preparation for these meetings, close liaison was established and maintained with the Project Officer, who made the required arrangements and who parti-

icipated in appointments, for this crucial first round of meetings. Two documents were prepared and reproduced which were critical to most of the discussions referred to above: a draft, detailed DME procedure code classification scheme (contained in Appendix G) and a description of the options to be offered to beneficiaries under the experiment (contained in Appendix H).

All four of the carriers who had agreed to participate in the experiment were visited during the month. They included: Kansas Blue Shield, Metropolitan Life Insurance Company, The Travelers Insurance Company and Washington Physicians Service. Typically at each site, and after appropriate introduction by the Project Officer, the experiment was explained in detail, including the roles of beneficiaries, physicians, suppliers and carriers. Beyond this, the actual requirements for systems changes and communication with participants were examined. In addition, the ER&A staff members were briefed by carrier personnel concerning the processing of DME claims and a walk-thru of facilities was made. These meetings included the Project Officer, various members of the ER&A staff, personnel of the participating carriers and SSA Resident Representatives and Regional Office personnel.

Meetings with SSA personnel were aimed primarily at explaining the experiment and trying to obtain their cooperation to the extent that their various organizations might become involved. During the initial meeting several new ramifications of the experiment became apparent: the necessity of involving SSA Regional Offices and District Offices was noted; the need for adequate identification and classification of DME was recognized; Part A providers might also

furnish DME on a rental or purchase basis, with claims being processed by Part A intermediaries; a Model B System DME Subsystem was being tested by SSA personnel, and would be available to carriers with support in the near future, adequate provisions for the experimental options and data collection were included; claims by some suppliers are not always processed in the same state but may be transferred to a supplier home office; the addition of a physiatrist to the Advisory Panel was recommended.

It should be noted that systems changes contemplated for the implementation of the experimental reimbursement procedures were the responsibility of both the carriers and the Government, inasmuch as: Kansas Blue Shield operated and maintained an EDS-derived computer system installation; Metropolitan Life designed, operated and maintained its own computer processing system; The Travelers utilized a Model B System for which they had maintenance responsibility; and Washington Physicians Service utilized the Model B System and was currently the test site for the DME Subsystem, contemplated to be completed by the Bureau of Health Insurance, Model B Systems staff by year's end.

During this period discussion also focused on the solicitation of additional carriers for the purpose of obtaining a larger sample and somewhat broader geographic coverage, particularly in densely populated areas. For this reason two other carriers were visited: Blue Cross Blue Shield of Greater New York and Blue Shield of Michigan. Both carriers expressed an interest in the experiment but indicated that further management approvals would be required prior to their participation.

The Project Manager was a principal speaker at the annual convention of the Rental Service Association, a national association of rental equipment suppliers, where the experiment was well received and discussed.

December 1976

The pace of activities on the experiment continued at a rapid rate during the month of December. Aside from continuing activities on a variety of aspects of the experiment, there were a number of unusually significant events during the period, as follows: one of the original group of four carriers rescinded its participation (Kansas Blue Shield); the BHI agreed to find a replacement and to obtain cooperation from others; ER&A assisted in the review of a DHEW Audit Agency report concerning DME; a methodology for developing administrative cost data was begun; and, a decision was made to hold the first meeting of the Advisory Panel during the latter part of January, 1977.

ER&A staff presented details of the experiment to various BHI, ORS and District Office representatives, at a meeting in the contractor's facility, in order to obtain their cooperation in several matters. BHI representatives stated pros and cons of large-scale versus small-scale studies, recognized the need for additional carriers in the more heavily populated states and indicated a willingness to aid in the effort of soliciting participation of additional carriers. ER&A agreed to supply District Office management in those areas involved in the experiment with materials regarding the project for distribution to the public. It was noted that the District Office is often the key point of contact of the beneficiary with SSA and Medicare.

With respect to carrier participation, numerous staff meetings and conversations with the Project Officer and the management of his organization were held. These discussions concerned the substitution of another carrier for Kansas Blue Shield in addition to at least two others to meet SSA requests for coverage. Questions of regional and geographic distribution, size of beneficiary population, size of claim load, type of data processing system and support in use, characteristics of beneficiary population, etc. were all considered in connection with a broad examination of the carriers. Additionally, a general concern was that SSA regional offices might prefer that certain carriers not participate. It was felt that a direct working relationship through the BHI Contractor Operations to the Regional Offices was necessary to help insure against repetition of the loss of a carrier.

Subsequently, further meetings were held with BHI to discuss the possibility of recruiting additional carriers. As a result of extended discussions several carriers were identified.

January 1977

The most important event during this period was the convening of a conference including the Advisory Panel in Baltimore, Maryland. Their recommendations were considered in hopes of facilitating the implementation of the project.

Details of this Advisory Panel meeting are found below as a "Brief Summary of DME Experiment Advisory Panel Meeting" package, which was forwarded to SSA as a report of conference activities.

BRIEF SUMMARY OF
DME EXPERIMENT ADVISORY PANEL MEETING

January 26 - 27, 1977

The first conference of the Advisory Panel took place in Baltimore during January 26 and 27, 1977. The occasion was also used to convene two additional submeetings and to obtain the participation of SSA headquarters and regional office personnel.

With respect to SSA personnel, participants included regional, headquarters and resident representative personnel who considered various aspects of the Experiment through probing questions, received full responses to their questions and through subsequent comments expressed their understanding and support.

In general, the meeting served as an opportunity for supplier representatives, government personnel, carrier representatives and Panel members to express their views on a variety of topics that impact on the Experiment, ranging from questions of SSA policy concerning the Experiment to detailed items as to inclusion of pre-existing and continuing DME beneficiaries. The comments of Advisory Panel members and other attendees were thought to be both useful and enlightening and will be taken into account in the implementation of the project.

The Project Manager chaired the meeting and explained in detail the various aspects of the Experiment. Questions were raised and responses were given by the Project Manager and, as required, by the Project Officer. Participation in the discussion was very broad and only a base summary is given here.

Two important procedural decisions regarding the Experiment were made as follows:

- 1) DME beneficiaries as of the starting date of the Experiment would be eligible to select the new options (and would be required to have the necessary documentation for them) and
- 2) physician's prescription of "indefinite" need would be interpreted to mean at least twelve months, thus making vitually all DME available for purchase if such medical necessity was shown.

A short description of the outcome of the Experiment in terms of data collection and analysis was presented. The Advisory Panel was informed that the major product of the Experiment would be a report containing claims data compiled by the carriers and collected, tabulated, and analyzed by Exotech. The organization of these data will allow for comparisons to be made between the alternative payment mechanisms available during the Experimental period. It was noted that many questions of concern in the DME area would not be answered by this Experiment although a subsequent evaluation study might consider some of them.

In regard to communications, beneficiaries will learn of the Experiment and the new reimbursement methods in several ways; the prescribing physician may offer some information; the participating supplier may explain the options; and the news media may bring the subject to the attention of beneficiaries. The beneficiary may also obtain complete details by contacting the Medicare carriers or the SSA District Office. Additionally, the suggestion was made that an important communications route might be to add a "stuffer" to mailings to beneficiaries that are ordinarily made by the carriers. Such stuffers could probably be sent without additional mailing cost and would reach beneficiaries from a source with which they are familiar.

Multiple messages will be required to reach beneficiaries. This includes an initial message, at least one other during the course of the Experiment and at least one more in advance of the end of the Experiment to announce its closing. Close cooperation with carriers will also be necessary to get these messages across.

In the separate meeting with supplier representatives, the outcome was essentially that they would apply the rental/purchase conditions to actual data and determine the impact on their industry. The results of this activity would be made available to the Project Manager.

Also under discussion was the content of the prototype contract to be made available to suppliers, in particular an addendum to the contract that would contain a 90-day warranty on the sale of used equipment. The warranty could become a serious problem in the case of the rental/purchase option. The supplier might well hesitate to grant such a warranty if after prolonged rental the equipment used has been damaged. Several suppliers present at the meeting insisted that suppliers would not grant such a warranty without prior examination of the equipment; they asked who would bear the cost of such inspection.

No guidance existing on this point, the Project Manager said that Exotech would study it for definitive resolution before the Experiment begins. Such study, he pointed out, might possibly require some modification of the warranty under discussion, though he was aware of the difficulty and possible delay in obtaining the concurrence of the General Counsel of the SSA.

In an extremely useful, separate meeting with carrier representatives, the status of activities in each site was examined. Succintly stated, Metropolitan requires additional information (which was subsequently sent) on the basis of which to determine the impact on their operations and costs associated with it. Travelers primary requirement was for DME Model System information awaited from SSA and desired that Exotech make the trips to their field installations originally promised. (These were scheduled to be carried out in February.) As to WPS, the Model Subsystem was scheduled to be tested within a short period and this organization is essentially ready to begin the Experiment in a relatively brief period.

An additional feature of the meetings was that much interest was expressed in improving the quality of the DME system and, in some cases, in adopting the procedure code system developed by Exotech and furnished to the carriers in the RFP for the Experiment.

Although all parties agreed that a uniform procedure code would be helpful they were informed that its adoption is not a requirement on participating carriers. Each carrier currently has its own procedure codes. However, Exotech has made available to carriers a rather detailed classification scheme which is being adopted in modified form in several locations. It is important that suppliers provide good description of the equipment to aid the carriers in processing claims and to establish the basic data for Exotech's data collection effort. It was suggested that suppliers be required to use standard nomenclature; however, it was unclear as to whether the carriers have the authority to impose this requirement.

The meeting was very well attended and there was lively discussion. A list of participants is attached.

ATTENDEES AT ADVISORY PANEL MEETING ON JANUARY 26 - 27EXOTECH RESEARCH & ANALYSIS, INC.

Libert Ehrman - Project Manager
Theodore Janssen - Principal Research Associate
Theodore Sumberg - Senior Research Associate
Seale George - Administrative Assistant
Michael Conlon - Senior Programmer
C. E. Morrison - Field Staff and Services Administrator
Robert Lyle - Systems Manager

ADVISORY PANEL

John McGaurn - Delcrest Medical Products
Richard Karlson - Abbey Rents and Sells
Donald McCullough - Rental Services Administration
Leonard Young - National Mediquip, Inc. and Rental Services Association
Jack Emery - National Association of Blue Shield Plans
Frank Wenger - American Academy of Physical Medicine and Rehabilitation
Edward Roseman - National Affiliation of DME Companies
Marvin Levand - American Rental Association

CONSULTANTS

Albert Mark - Public Relations
William Stephens - Legal

SOCIAL SECURITY ADMINISTRATION

Theodore Saffran - Project Officer
John Polk - Regional Representative, Philadelphia Region
Preston Lowen - On-site Representative to Metropolitan Life
Donald Wilson - Regional Representative, Boston Region
Migdalia Vargas - Regional Representative, Chicago Region
Janice Jackson - District Office Representative liaison
John Bullock - Systems
William Lutts - Contractor Operations
William Zavonia - Contractor Operations
Victor Forman - Quality Assurance Programs
Chester Robinson - Program Evaluation and Planning
Fred Stark - BHI Policy
Leon Bernstein - Evaluative Studies

CARRIER REPRESENTATIVES

Gina Terry - Washington Physicians Service, Seattle, Washington
Thomas Batters - Metropolitan Life, Utica, New York
Herbert Schrader - The Travelers Insurance Company, Hartford, Connecticut

OTHER ATTENDEES

C. A. Siegfried - American Rental Association
Roy Morris - American Rental Association

Further details concerning preparations for and convening of the First Advisory Panel meeting as well as the separate carrier and consultant meetings, mentioned above, may be found in Appendix I.

Negotiations with the BHI during the month centered on the solicitation of additional carriers. Stated at the Advisory Panel meeting was the intent to solicit carriers within the Regions as listed below:

New York Region: Group Health Incorporated

Chicago Region: Blue Shield of Michigan

or Nationwide Mutual Insurance Company

Kansas City Region: General American Life Insurance Company

or Iowa Medical Service

Dallas Region: The Equitable Life Assurance Society of the U.S.

San Francisco Region: Blue Shield of California

February 1977

Efforts during the month of February included a continuation of meetings with carriers, both for the purpose of soliciting their participation and explaining the project to field offices of cooperating carriers. These meetings included a solicitation visit to Nationwide Mutual Insurance Company in Ohio and explanation visits to The Travelers Insurance Company installations in Minnesota, Mississippi and Virginia. In addition, the Project Manager and the Project Officer were invited speakers to the American Rental Association (ARA) annual convention. They addressed two separate meetings of members of the ARA and, in

addition, held a small meeting with key supplier organization representatives. With respect to the former, the nature of the experiment, the current areas involved and the alternative payment procedures were described. With respect to the latter, the primary subjects discussed were the implications of lump-sum payments and the rental/purchase options.

During the month, Washington Physicians Service held a Medicare Workshop in Seattle to which the Project Manager and Principal Investigator were invited. The Workshop included representatives from the seventeen bureaus in the State, SSA Headquarters, Regional and Resident Representatives, other insurance company representatives and state officials from the Department of Social and Health Services. The Workshop began with a presentation of the Model B System Release 76-1 and a subsequent discussion of the status of various reporting and clerical changes that would be necessary to process claims with the revised computer system. Interest then focused on the DME Subsystem and the experiment. SSA Headquarters Model B Systems personnel outlined the DME Subsystem by stating that it was designed to automate the task of processing DME claims with a minimum amount of clerical effort. During a description of the DME Subsystem it was noted that provision for all the alternative reimbursement procedures to be offered during the experiment had not as yet been made. SSA Model B Systems was apprised of this situation subsequent to the presentation and agreement was reached to begin work to include all the experimental options immediately. A meeting was scheduled in early March to review these efforts. It was the opinion of ER&A that these provisions should be included before the DME Subsystem went on-line in Washington to expedite implementation of the experiment in that area.

It was also noted that several months earlier, ER&A had been assured by BHI Systems personnel that the DME Subsystem would allow for the experimental options and data collection requirements. It was planned that implementation of the Subsystem would be effected on or about March 22, 1977, a delay of approximately one month from the previous schedule. The Project Manager presented details of the experiment. Attendees seemed satisfied by the explanations and saw no major obstacles to implementation of the experiment in Washington in the near future.

March 1977

A major DHEW reorganization, creating the Health Care Financing Administration (HCFA), occurred this month. Responsibility for both Medicare and Medicaid programs was transferred from the Social Security Administration and the Social and Rehabilitation Services Administration. Although the agency was formally announced at this time, organization within the agency took place over the next two years. Therefore, references to organizations of relevance in the pages that follow may at times use older SSA, preliminary HCFA or current HCFA designations.

Efforts during the month of March on the Durable Medical Equipment experiment were characterized by: meetings with the New York Regional Office, the New York headquarters of Group Health Incorporated (GHI) and subsequently with the Miami, Florida officials of GHI; a meeting with the Equitable Life Assurance Society of the U.S. in Albuquerque, New Mexico; a meeting with Nationwide Mutual Insurance Company in Columbus, Ohio; presentation and participation in

the annual convention of the National Affiliation of Durable Medical Equipment Companies (NADMEC) in Los Angeles, California; a meeting with Abbey Rents and Sells in Los Angeles, California; a meeting with the BHI Model B System staff in Baltimore; and a meeting with the BHI Systems staff in Baltimore.

Of additional note were: the efforts undertaken by Exotech staff in compiling and disseminating a brief summary of the Advisory Panel meeting; development of inputs to the evaluation RFP; provision of inputs to the legal Consultant concerning the development of model contracts for suppliers; collection of materials from carriers concerning mailing lists, procedural handbooks and classification methodologies of DME; maintenance of contact with carriers and suppliers relating to project developments; and continuance of research into administrative cost questions.

The cooperation of the New York Regional Office was sought to assist in soliciting Group Health Incorporated to participate in the project. At the suggestion of the BHI a meeting was arranged with the Regional Medicare Director and staff. The Director gave full support to the experiment and spoke with both GHI and Equitable Life Assurance Society executives to urge their participation.

Subsequently the New York office of GHI was visited by the Project Manager and Project Officer. Following a detailed presentation of the experiment it was noted that to obtain geographic and demographic representation, it was thought wise to include a large city, such as New York, and the special elderly population of the

Miami area. A week after this visit, GHI informed the Project Officer that they had decided to take part in the experiment and arrangements were made for a visit to their Florida site. An initial meeting was held with the GHI staff in Florida for the dual purpose of allowing ER&A to present the experiment to appropriate GHI and SSA personnel and allowing the GHI staff to acquaint ER&A and the Project Officer with the procedures followed in processing DME claims.

A solicitation meeting was held with the Equitable Life Assurance Society of the U.S. field office in New Mexico. They were interested in participating in the experiment but information concerning systems questions was needed from their New York office. It was noted that Equitable was a Model B System user and that maintenance was provided by SSA. The computer operation itself was operated from the New York office and it was arranged that contact be made with them to explore the systems questions involved.

A follow-up meeting, to that held in February with Nationwide Mutual Insurance Company, was conducted for the purpose of clarifying questions concerning the experiment and the participation of Nationwide. The Project Officer's Director, Dr. James Kaple, requested that they give serious consideration to participation in the experiment, however, the matter was left with Nationwide to inform the ER&A as to their decision.

The Project Manager met with the Advisory Panel member who represented the National Association of Blue Shield Plans to obtain assistance in recruiting additional carriers. The D.C. Medical Service, Colorado Blue Shield and Rhode Island Blue Shield were suggested as possible solicitees.

As noted previously, at the Washington Physicians Service Medicare Workshop, SSA Model B Systems personnel were informed that provision in the DME Subsystem for all the experimental procedures had not been made. A meeting was held with Model B Systems staff to review necessary requirements for the experiment. It was anticipated that changes would be made to the DME Subsystem prior to its installation and testing at WPS on March 18-20, 1977. During the latter part of the month a subsidiary question was raised concerning the ability of the Subsystem to do the calculations necessary to the discounting procedure for the rental/purchase conversion options. A meeting was scheduled in April to discuss this effort.

During the latter part of March the Project Officer received an inquiry from the New York Regional Office about the effects of the DME experiment on the SSA payment record processing system. A question arose concerning rejection by the SSA processing system of payment records involving 100% payment for the used equipment alternatives. A meeting with BHI Systems staff was held to explore possible solutions. Systems personnel provided a ready solution to the problem, however, agreement by other SSA officials was considered necessary before action could be taken. Consequently, an early April meeting was scheduled with appropriate BHI and ORS officials, the Project Officer and ER&A.

Later activities in the month included presentations by the Project Officer and Project Manager at the annual meeting of NADMEC. The meeting was well attended and numerous questions were raised from the floor. There appeared to be general enthusiasm and a spirit of cooperation with respect to the experiment.

Following, a visit was made by the Project Manager and Project Officer to the headquarters of Abbey Rents and Sells and their Glendale store. The Glendale Adventist Medical Center, a client of Abbey, was also visited so that activities involving the provision of DME in a physical rehabilitation setting could be viewed.

April 1977

During the month, meetings with carrier officials continued, both to solicit their cooperation and to explore their operations. Nationwide Mutual Insurance Company and Metropolitan Life Insurance Company (one of the four original participating carriers) officially declined to participate further in the experiment. The Project Officer and ER&A staff prepared a list of budget elements to be presented to carriers so as to allow for their preparation of a budget to be submitted to the Project Officer. These individual budgets would become the basis for separate contracts between the Project Officer and each carrier. The Project Officer would be the official Contracting Officer with cognizance over these contracts which were separate and distinct from the carriers' current Part B contracts. A series of working sessions was held with Model B Systems personnel to complete specification of the necessary systems changes for the experiment. A meeting was also held with Sears Roebuck & Company to explore their provision of DME in the marketplace.

Of additional note were: efforts undertaken by ER&A staff in continuing provision of inputs to our legal Consultant concerning the development of model

contracts for suppliers; collection of materials from carriers concerning mailing lists, procedural handbooks, classification methodologies of DME and other data relating to current provisions for DME; development of test claims to be utilized by the Model B Systems staff in testing the DME Subsystem; and continuance of research concerning administrative costs.

As noted previously, a meeting between appropriate HCFA officials of BHI Systems, BHI Model B Systems, BHI Division of Contractor Operations and the Office of Research and Statistics was convened to discuss the generation of payment records on claims involving 100% reimbursement for used DME. It was agreed that carriers would flag their systems to prevent generation of these payment records and use Part II of the form 1522a to reflect these money amounts. It was further agreed that an Identical Memorandum to the carriers and Regional Offices would be drafted, reviewed and distributed in the near future.

The Project Officer and ER&A staff determined that the following elements, as a minimum, should be included in the budget as submitted by any participating carrier.

1. Installation of the DME Subsystem, based on the detailed materials to be provided by BHI Model B Systems;
2. Monthly copies of a DME output tape to be sent to ER&A;
3. Provision of a one-year and a two-year history of DME experience prior to the start of the experiment;
4. Training of DME claims processing personnel;
5. Participation at Advisory Panel meetings;

6. Participation in a Systems Meeting;
7. Participation in a Claims Processing Meeting;
8. Insertion of "stuffers" in EOMB letters;
9. Participation in on-site meetings regarding the public information program
10. Participation in meetings with supplier and/or physician groups (possibly part of previously planned meetings with these groups);
11. Press releases as necessary; and
12. Provision for mailings to suppliers and physicians.

These budget elements were described to the carriers by ER&A and assistance was provided in structuring the general budget.

Also, as noted previously, meetings with the Model B Systems staff concerning the ability of the DME Subsystem to do the calculations necessary to the discounting procedure for rental/purchase options were held. It was agreed that the Model B Systems Branch would include the appropriate programs in the Subsystem. Also indicated, was the availability of the Subsystem for installation at any carrier maintained by BHI as the automated diary was considered an enhancement of the overall system. The possibility of convening a Systems Meeting oriented to carrier officials was raised and agreement was reached that the Branch could support a meeting with carriers to whom they were responsible for maintenance although others could be invited guests. Several working sessions were held to continue reviewing progress of the DME Subsystem. In addition, ER&A and the Project Officer agreed to furnish appropriate test cases to allow for testing of the DME Subsystem. Late in the month a meeting was held to complete a point-by-

point review of specifications submitted to the Project Officer by the Model B Systems Branch. Required corrections and clarifications were prepared and it was concluded that the only reasonable and valid "sign-off" that could be made by ER&A and the Project Officer would be with respect to the concept and logic of the processing steps and the discount algorithm for rental/purchase conversion. Model B Systems personnel then joined the meeting and agreed to the proposed corrections and clarifications and the limited context of a sign-off.

To honor the commitment made to Equitable's Albuquerque staff, a meeting was held with the carrier's headquarters organization in New York City. Detailed discussion of the experimental payment options and the effort being made by the HCFA Systems personnel to accomodate the experiment and the DME Subsystem within the Model B System took place. Questions concerning the ability of the Subsystem to handle on-line operations as well as batch processing were raised. ER&A indicated that, to the best of their knowledge, the on-line Subsystem would be operational shortly after the batch version. Equitable discussed the question as to inclusion of all four of the Part B operations and agreed to advise ER&A as to their decision in the near future.

A full-day meeting was held with personnel of Sears Roebuck & Company regarding DME. The Project Officer and Project Manager provided a detailed presentation of the Medicare Part B program, the terminology associated with the field and a full explanation of the experiment. Sears personnel stated that the firm was a national supplier of home health care products, mostly through catalog orders, but offered only on a purchase basis. They compose and distribute a

special catalog which identifies the items offered for sale and contains information about the Medicare program, approved by Medicare, and coverage issues. Many questions were raised as to the policies and operations of the Medicare program and full explanations were given in response.

A meeting was held with the Metropolitan Life Insurance Company in New York City primarily to assist them in structuring a budget for the experiment to ensure provision of the required activities. All facets of the budget elements were discussed. There was also a discussion of the work being done by the Systems personnel at HCFA in Baltimore and how the DME Subsystem was being arranged to accomodate the experiment. The Company was encouraged to request copies of the Model B changes being made for the experiment through the Regional Office as a reference to the types of changes that they might be making to their own system. Metropolitan requested that their Kentucky operation be included in the experiment as uniform implementation and subsequent operation would be easier for them from a computer processing standpoint. It was suggested that this alternative be posed to the Project Officer in writing. As noted above, after consideration of various system architecture priorities, Metropolitan decided it was unable to continue its participation in the project.

A similar budget preparation meeting was held with Group Health Incorporated in New York City to discuss the elements that might provided for in the budget to be submitted to the Project Officer. Progress made to date in revision to the DME Subsystem and cooperation with BHI Model B Systems was discussed. GHI was urged to take advantage of the offer of the Model B Systems Branch to provide

the changes being made in the Subsystem by requesting this information through the Regional Office.

The final meeting of the month with carrier representatives was held in Washington with the D.C. Medical Service. Details relating to the character of the experiment, the reimbursement alternatives, changes being made in the Model B System and Subsystem for DME, organization of the project and other related issues were examined. It was noted that this carrier was a Model B System user with maintenance provided by the Government. Installation of the DME Subsystem, therefore, would be the responsibility of HCFA, in accordance with BHI commitments. In the discussion that followed carrier personnel stated that they would consider the experiment as a possibility and would advise ER&A as to whether the organization would participate.

May 1977

Activity during the month of May was characterized by further efforts to solicit carrier participation, including: a meeting with Blue Shield of Rhode Island; a series of working sessions to prepare and review test claims for the DME Subsystem (intended for utilization in a testing environment at HCFA Central Office); preparation of draft public information letters to be initially reviewed by the Project Officer; and, project coordination with respect to carriers, Consultants, HCFA and staff. Also, D.C. Medical Service indicated that they would not be able to participate in the experimental project.

A briefing was held at the Blue Shield of Rhode Island office in Providence for the purpose of allowing the ER&A staff to present details of the experiment with a view towards soliciting their participation. Following substantive discussion of the experimental requirements it was left up to carrier to consider participation and to notify ER&A as to their intentions within the next two weeks.

During a series of working sessions held at HCFA, the Principal Investigator and Project Officer compiled a set of claims which were designed to fully test the operation of the DME Subsystem. Several claims were constructed for each reimbursement alternative that might be encountered during processing. Each unique or new feature of the experimental provisions was to be tested, including:

1. Identification of the type of claim (i.e., rental, purchase or rental/purchase);
2. Identification of the condition of equipment (i.e., new or used);
3. Decision regarding lump-sum versus diary payment;
4. Decision regarding waiver of co-insurance;
5. Automated handling of the discounting procedure for rental/purchase conversion; and
6. Determination of the amount to be paid.

It should be noted that the Subsystem was designed to automate, to the fullest extent possible, the handling of all DME claims. Minimal inputs were required on the part of clerical claims processors and essentially the computerized Subsystem would make all determinations relative to the type of payment and amount to be paid. These cases were to be used in a testing environment at HCFA Central Office, reviewed by ER&A and the Project Officer and further utilized during

testing of the Subsystem at Washington Physicians Service in Seattle on July 8, 1977. Details of these test cases are found in APPENDIX K.

Numerous telephone conversations were held with carrier executives during the month. In the course of these discussions, development of the Subsystem and inclusion of items in the budget were of major importance. Timing of implementation of the experiment, which in turn depended on final testing and implementation of the DME Subsystem, was an additional topic in the planning process. The Equitable Life Assurance Society also indicated their interest in participating and requested that ER&A staff meet with the directors of their field offices in Idaho, New Mexico, Tennessee and Wyoming.

June 1977

Work on the DME Experiment for the month of June centered around further efforts to solicit carrier participation, including: a meeting with Colorado Blue Cross/Blue Shield in Denver, Colorado; a series of meetings to solicit participation and assist in budget preparation with the field offices of Equitable Life Assurance Society of the U.S. in Boise, ID., Cheyenne, WY. and Albuquerque, NM.; working sessions with the Washington Physicians Service and the Seattle Regional Office concerning the public information materials; systems specifications and operations for handling DME claims; budget preparation; further meetings with personnel of Sears Roebuck & Company to solicit their participation as a supplier; review of draft materials concerning prototype contracts to be made available to DME suppliers; and continued efforts to promote the progress of the DME

Subsystem. Other activities included close contact and coordination with all project entities, particularly carriers. In addition, telephone contact was made with supplier organizations engaged in the sale of DME, specifically Penney's in New York and Montgomery Wards in Chicago. Materials describing the experiment were forwarded to appropriate personnel of these organizations for review. Notification was received from Rhode Island Blue Shield declining participation in the experiment. Results of the test claims provided to BHI Model B Systems were not as yet received, however, preparations for the Systems Meeting were undertaken.

Earlier, contact was made with the Equitable Life Assurance Society of the U.S. soliciting their participation in the experiment. An initial meeting was held with the field office manager in Albuquerque, New Mexico. Subsequently, a meeting was held with headquarters personnel in New York City. At the request of Equitable and the Project Officer, ER&A held meetings with the other field offices. However, prior to this series of meetings, the field office managers were briefed concerning substantive issues involved in the experiment, so that the field visits were simultaneously presentation meetings and budget preparation discussions. The format of the meetings followed that which occurred previously including discussion of the experiment in general (background, history and legislation) and in particular (scheduling, Subsystem changes, training, public information campaign, data collection, location of the experimental areas, organization for the project, etc.). It should be noted that there was good understanding of and support for the experiment in all locations. Preparations for a similar meeting with the Nashville, Tennessee field office with a follow-up

meeting at headquarters in New York City were scheduled. Both systems changes and budget preparation for the overall Company budget would be considered. It was assumed the Equitable budget would be submitted to the Project Officer for approval shortly thereafter.

A series of working sessions was held with representatives of Washington Physicians Service and the Seattle Regional Office primarily to bring them up to date on various aspects of the experiment and to work towards implementation. Following a brief description of the project, the Principal Investigator detailed the test cases that were to be utilized at WPS in the near future. Regional Office representatives indicated that problems with the price screen updating operations were likely to delay the testing. They also requested that the Principal Investigator be detailed on-site for the testing. It was agreed that such would be the case. Work then focused on the public information campaign. Draft materials for the letters to beneficiaries, suppliers and physicians were reviewed. It was decided that both WPS and the Seattle Regional Office would edit the materials and forward copies to ER&A for review by staff and the Project Officer. Plans were then formulated for conduct of the information campaign. Subsequent discussions entailed questions of the budget which was soon to be completed and submitted to the Project Officer.

A briefing was held at Colorado Blue Cross/Blue Shield in Denver to solicit their participation in the experiment. An overview of the project was provided to their staff and a representative of the Denver Regional Office. Carrier attention immediately focused on two issues, namely, difficulties arising from imple-

mentation of current experiments and problems in effectively changing computer programs in the Model B System. A lengthy discussion ensued in which assurances were given to the carrier that the relevant Subsystem would be fully tested and operational prior to being released to the carrier. The presentation then focused on the approach being taken in terms of scheduling, public relations effort, data collection and the classification of DME. With respect to the public relations effort, the carrier detailed previous experiences with HCFA experiments in which mass mailings to beneficiaries led to "disasterous" results and recommended that mailing be made via the EOMB statement. There was general support for the concepts involved in the experiment, however, reservations concerning the involvement of the carrier were thought to preclude their cooperation and participation.

July 1977

During the month, ER&A efforts to assist various carriers continued. The majority of these activities were concerned with budget preparation. As scheduled previously, the Nashville office of the Equitable Life Assurance Society was visited. Solicitation efforts in California included meetings with California Blue Shield and Occidental Life Insurance Company of California. The former carrier, with whom a relationship had been established during the Protocol development period, regretfully declined to participate citing possible changes in their computer system subcontract. Occidental, on the other hand, indicated an interest in the project and agreed to notify ER&A concerning participation in the near future. Colorado Blue Cross/Blue Shield, visited in the previous month, also declined to participate in the project. On another topic, results of the test claims

were still not forthcoming. However, at the request of the Project Officer, plans were made for the Principal Investigator to monitor on-site testing at the King County Medical Blue Shield facility in Seattle (named the Model B System Test Site for the DME Subsystem) early in August. The Systems Meeting referred to above was scheduled to be held at HCFA Headquarters in Baltimore on August 9, 1977.

Several internal working sessions were held during the month concerning: public relations materials; the prototype supplier contracts and documentation provided by the legal Consultant to the project (found in APPENDIX L); review by the Project Officer and industry consultants of the aforementioned documents; continued efforts to promote the progress of the DME Subsystem; telephone contacts with industry consultants and a member of the Advisory Panel concerning the possible participation of a California carrier; telephone contacts with several suppliers whose involvement was sought in the project; and, contact with numerous carrier personnel in an effort to further project implementation.

A briefing was held at California Blue Shield in San Francisco for the purpose of allowing the Project Officer and ER&A staff to present the experiment to appropriate personnel of the carrier as well as the San Francisco Regional Office. The meeting opened with a brief overview by the Project Officer of the legislative and administrative history concerning DME that lead to the current contract. It was noted that, in 1974, during the Protocol development effort relating to this project, members of the ER&A staff and the Project Officer had visited CBS to explain the project and solicit their cooperation. Also noted was

the fact that very little substantive change had been made to the payment mechanisms since that time although project details and plans were now more specific. At this point a full presentation of the experiment ensued. During the discussion, questions arose concerning systems changes and their impact on processing operations. The forthcoming Systems Meeting was announced and the Project Officer invited CBS to send a representative. Following the presentation by ER&A staff, CBS personnel detailed the status of their subcontract with Electronic Data Systems, Inc. and indicated that plans were being made to issue an RFP for competitive systems bids in the near future. It was decided by CBS that this effort would preclude their participation in the experiment although they were sympathetic to and interested in the project.

Occidental Life Insurance Company in Los Angeles, California, was the next carrier visited in an effort to increase the size and coverage of the experimental project. At a meeting with Occidental staff and their Resident Representative, a full description of the experiment was given. Details of the efforts of the Part B Model Systems staff were discussed even though Occidental was not a Model B carrier. The Project Officer invited their participation in the upcoming Systems Meeting and it was indicated that a representative would be sent. During subsequent discussion Occidental executives noted that they were in a position to consider participation owing to their considerable success in reducing costs and improving operations in the recent past, however, the impact of the experiment would have to be carefully weighed before a decision to participate could be transmitted. It was felt that the Occidental personnel were very supportive of the concepts involved in the experiment and with that in mind the Project

Manager continued with a description of the budget preparation activities. Following a walk-thru of the entire installation, Occidental indicated that a decision would be made in the very near future.

In continuation of activities relating to the participation of the Equitable Life Assurance Society, a visit was made to their Nashville office. The Resident Representative and a representative from the Atlanta Regional Office were present. The meeting was simultaneously a presentation of the experiment and budget preparation discussion. All aspects of the project were touched upon. Again, as with their other field offices, Equitable personnel were very supportive of the project and preparations were made to hold a follow-up meeting with Company officials in New York City to discuss overall budget and systems activities. The headquarters meeting with Equitable occurred later in the month.

In addition to the headquarters meeting with Equitable, a meeting was held with Group Health Incorporated in which the Project Manager assisted the carrier in detailing the various items to be included. It was expected that both the GHI and Equitable budgets would be submitted to the Project Officer shortly.

August 1977

Perhaps the most important event that took place during August was the Systems Meeting in Baltimore hosted by BHI Model B Systems on August 9, 1977. A list of attendees and a brief summary of the meeting is be found below. Testing of the DME Subsystem at the King County Medical Blue Shield facility was also

monitored during the first week of the month. Although testing was not completed and results of the test claims were not available it was hoped that the process would be completed in the very near future. Review sessions were held with the Project Officer to consider both the prototype contracts to be used by suppliers (found in APPENDIX L) and the public information literature edited by WPS (found in APPENDIX M). Comments from the industry Consultants concerning the prototype contracts were forwarded to the legal Consultant for review. Toward the end of the month the edited public information materials were distributed to the various participating carriers for their review.

A meeting was held with personnel of BHI Model B Systems Branch, Seattle Regional Office, Washington Physicians Service, King County Medical Blue Shield and the Principal Investigator to review progress of Subsystem testing. A plan for testing the Subsystem was set forth that included a full test on August 7, 1977 during which time the computer system could be fully dedicated to testing. Although it was anticipated that results of the test claims might be forthcoming, difficulties in portions of the Model B System prior to the DME Subsystem precluded this. Efforts were undertaken by BHI Model B Systems and King County Medical Blue Shield personnel to alleviate these problems and continue testing in the future. It was thought that testing might be completed by late August or the middle of September.

A systems oriented meeting, hosted by BHI Model Systems Branch was held at SSA Headquarters in Baltimore, MD. on August 9, 1977. The intent of the meeting was a presentation of the DME Subsystem including the provisions necessary to

conduct the experiment. All carriers who were currently involved in the experiment were represented as well as several others. Mr. R. Gwyn, Branch Chief, introduced himself and the subject to the audience and indicated that all programs and documentation would be provided to interested carriers upon their request. Following Mr. Gwyn, Mr. J. Mayhew presented details of the Model B System, the DME Subsystem and the interaction between the two. A question and answer period ensued in which many aspects of the operation of the Subsystem were clarified. Next on the agenda was a brief description of the provisions in the DME Subsystem to allow for the DME experiment given by Mr. J. Bullock. During the afternoon, further questions were asked by interested parties and either resolved immediately or referred to appropriate Government personnel for responses. In general the meeting was considered to be very helpful in developing an understanding of the Subsystem. An attendance list follows.

Concerning implementation plans for the experiment at Washington Physicians Service, ER&A continued supporting the carrier by scheduling a review and planning session with their staff to be held early in the following month.

Of further note were the budget submissions by all four carriers currently participating in the project. Upon approval by the Project Officer and other appropriate HCFA components efforts toward implementing the experiment at their sites would begin. However, it was noted that all currently participating carriers were still dependent on systems programming, testing and documentation activities being undertaken by BHI Model B Systems at the WPS Test Site in Seattle, as they are all Model B System users.

ATTENDEES AT THE SYSTEMS MEETING
AUGUST 9, 1977

HCFA PERSONNEL

Shirley Brooks, Boston Regional Office
John Bullock, Part B Systems
Bobby Childers, Resident Representative, Travelers Virginia
Jack Cooper, Seattle Regional Office
Stan Dickson, Atlanta Regional Office
Mary Ann Durham, Part B Systems
Marianne Faulstich, Part B Systems
Leonard Gizinski, Contractor Operations
Jim Gordon, Part B Systems
James Grover, Part B Systems
Ron Gwyn, Part B Systems, Branch Chief
Frances Harris, Program Policy
Wade Harris, Contractor Operations
Roscoe Heigh, BHI Systems
Stanton Levin, Part B Systems
Lew MacKinnon, BHI Systems, Branch Chief
Joe Mayhew, Part B Systems
Sally Robinson, Part B Systems
Theodore Saffran, OPFR, ODE, Project Officer
Fred Stark, Medicare Policy

CARRIER PERSONNEL

Blue Cross/Blue Shield of South Carolina
Martha Spires
California Blue Shield
Walter Cardwell
Equitable Life Assurance Society of the U.S.
Bob Bergamini
Helen Duncan
Richie Isalde
William Seal
Group Health Incorporated
Jamie Alvarez
Ken Kramer
Bob Higgins
Barbara Sangetti
Elizabeth Wang
King County Medical Blue Shield
Jerry Newton
Metropolitan Life Insurance Company
Joel Swindells
National Association of Blue Shield Plans
Jack Emery
Occidental Life Insurance Company
Neil Bass
Richard Hedlund
The Travelers Insurance Company
Peter Anderson

EXOTECH RESEARCH & ANALYSIS, INC.

Libert Ehrman
Theodore Janssen
Robert Lyle
Seale George

September 1977

During the month of September major progress was made involving the implementation of the experiment in the state of Washington, including numerous telephone and on-site contacts with Washington Physicians Service, King County Medical Blue Shield, Medical Service Bureau of Spokane County and the Seattle Regional Office. Efforts continued towards furthering the system installation aspects of the project. October 31, 1977 was set as the date on which the experimental reimbursement alternatives would become operational in Washington. A schedule for implementation of the Subsystem at the various Equitable sites was also drawn up. Contacts with the industry Consultants pertaining to their role in up-coming supplier meetings were made. In addition, contacts with all the participating carriers were made to obtain historical data relating to DME claims.

At the request of the Project Officer, Federal Medicaid officials in Washington, D. C. were contacted for the purpose of explaining the experiment and determining if additional coordination with Regional and State Medicaid personnel was necessary. At the Federal level also, the Project Officer entered into contracts for operation of the experiment with the following five carriers:

The Equitable Life Assurance Society of the U.S.

Group Health Incorporated

Occidental Life Insurance Company of California

The Travelers Insurance Company

Washington Physicians Service

A two-day working session was held at Washington Physicians Service to finalize public information materials and schedule implementation activities for the experiment. Those present represented Washington Physicians Service, King County Medical Blue Shield, Medical Service Bureau of Spokane County, the Seattle Regional Office and ER&A. Final copies of the beneficiary "stuffer", supplier letter and physician letter were reviewed (Examples utilized by WPS in the public information campaign may be found in APPENDIX M). Regional Office personnel presented draft materials for a program circular to the District Offices and a general press release which were to be finalized shortly. The following schedule was made concerning implementation activities for the experiment.

Week of 9/26 - mail supplier and physicians letters

October - December - Mail beneficiary letter with EOMB

October 10 - DME Workshop, Seattle

October 12 - DME Workshop, Spokane

October 25 - Supplier meeting, Spokane

October 27 - Supplier meeting, Longview

October 28 - Supplier meeting, Seattle

October 31 - Implement Experiment

Following these working sessions, the Principal Investigator reviewed training materials to be utilized in the DME Workshops. In addition to these meetings, several sessions were held separately with personnel of the Region X Office in Seattle to discuss contingency planning should the DME Subsystem not be fully operational by the end of October.

In the middle of the month ER&A staff and the Project Officer again met with Model B Systems personnel culminating several weeks of continuing discussions on problems of implementing the DME Subsystem in Washington, obtaining runs of the sample claims prepared for testing and the prospect for implementing the Subsystem in the several states served by Equitable. The results in Washington, although not complete were considered to be progressing so that an October 31 starting date for the experiment could be met. A schedule providing for start-up in all of the Equitable sites by the end of December 1977 was presented and found acceptable by the Project Officer.

A meeting was held with Federal officials with responsibility for the Medicaid program to explain the ramifications of the experiment. The Project Officer, Project Manager and Principal Investigator reviewed: the legislative and administrative background of the project; the impact of the experiment on payment procedures; and the possible impact on state budget requirements due to an increase in lump-sum up-front payments to beneficiaries or suppliers. It was deemed necessary that contacts be made with Regional Office personnel and state Medicaid officials. No major difficulties in coordinating the project were foreseen although it was noted that the states administer Medicaid in a non-uniform manner.

October 1977

Activity during the month of October on the project was characterized by concentrated efforts to implement the experiment in the State of Washington: including a series of training material preparation meetings, clerical workshops

and supplier meetings in several locations in the state; numerous telephone conferences and on-site meetings with staff of the Washington Physicians Service, the Medical Services Bureau of Spokane County, the King County Medical Blue Shield and the Seattle Regional Office; meetings with the industry Consultants to prepare for the supplier presentations; continued contact with BHI Model B Systems staff to attempt to implement the DME Subsystem. Meetings with staff of the Equitable Life Assurance Society of the U.S. from all field locations were held in Albuquerque, NM to discuss clerical procedures for the DME Subsystem and the experiment. Follow-up with the various carriers to obtain historical data tapes was undertaken. Scheduling of meetings with staff of Occidental Life in Los Angeles, CA. were made for the following month. In addition, many internal sessions to prepare for the large number of presentations in which ER&A staff would participate took place.

A three-day presentation by BHI Model B Systems personnel concerning the DME Subsystem was held in Albuquerque, NM for Equitable field and home office staff. On the second day of the proceedings, the Project Manager and Principal Investigator participated with respect to the alternative payment mechanisms available during the experiment and their relationship to the DME Subsystem. In addition, efforts were made to outline a schedule for implementing the experiment in the sequence in which activities must occur. Possible supplier meeting locations were discussed as well as the number of meetings thought to be necessary in each of the four states in which Equitable is the Medicare carrier. The public information program was discussed in relation to the timing of implementation and the necessity for early mailing of the materials was stressed.

In summary, it was felt that a four to eight week lead time would be necessary to accomplish all the pre-implementation activities for the Equitable sites if they were all to become operational simultaneously. Following the Workshop, a conference call was held between Equitable home office and field staff, ER&A, BHI Model B Systems and the Equitable subcontractor for data processing services, Informatics, in which an attempt was made set an implementation date for the experiment. It was clear that no such date could be set prior to delivery of the DME Subsystem by BHI as well as review by Informatics. However, it became apparent that a date of March 1, 1978, might be attainable if sufficient resources could be brought to bear on implementing the DME Subsystem.

A series of meetings and working sessions was held at the locations of the various organizations listed above for the purpose of reviewing and preparing materials for the upcoming clerical workshops and supplier meetings. Clerical documentation prepared by Washington Physicians Service, King County Medical Blue Shield and the Medical Service Bureau of Spokane County was reviewed and updated as appropriate. Plans were made for the presentations to be included in the clerical workshops since the major participants were all present (note agenda in the report of the clerical workshops). In addition to these activities, the Principal Investigator spent considerable time attempting to resolve difficulties with the implementation and testing of the DME Subsystem. It must be recalled that the implementation date set for Washington was October 31, 1977, and much work remained on the system before it could be made operational. In fact, little testing had been successful at this time and therefore many of the clerical procedures that would have to be followed were not known to the carrier's staff.

Attempts were made through the Regional Office as well as Central Office to apply more resources to solving the unresolved systems problems. In addition, a request by the carrier and Regional Office to allow for a waiver of regulations specified in the Part B manual needed additional review which was accomplished during this visit. Clerical training workshops were held in the State of Washington to introduce procedures for the DME Subsystem and explain the ramifications of the DME experiment to appropriate Bureau personnel in the Washington state system. The presentations were very well received and the clerical documentation prepared by staff of the Washington Physicians Service, the Medical Service Bureau of Spokane County and the King County Medical Blue Shield was well thought out and presented. It would serve as an extremely useful guide for the other carriers involved in the experiment. Rather than following the schedule given previously, the Workshops were held in Seattle on October 21 and 24 and in Spokane on October 26. The agenda for these Workshops follows.

AGENDA

9:00	Nancy Thornton	Introduction and opening remarks
9:15	Sue Peringer	Brief overview of DME Subsystem and experiment. Explanation of - coordination between Model B System and Subsystem - reasons for combining implementation of subsystem and experiment - extended rentals
9:40	Ted Janssen	Background of ER&A. Describe existing payment options. Describe new payment options.
10:00	Ted Janssen	Questions and Answers
10:15		<u>BREAK</u>
10:30	Claudia Coman	Coding instructions and use of DME Manual
12:30		<u>LUNCH</u>
1:30	Candy Block Claudia Coman Sue Peringer	Work thru examples with bureau personnel
2:30	Candy Block Sue Peringer	Explanation of Model B System effect on DME claims; new edits, exceptions, pricing, duplicate checks, query.
3:00		<u>BREAK</u>
3:15	Claudia Coman	Transaction forms
3:35	Candy Block	Reports
4:00	Claudia Coman Sue Peringer	Conversion of existing files
4:30	Pat Anunsen	Budget and implementation information

Supplier meetings were held in only two sites in Washington as the response to mailings for the Longview meeting did not generate sufficient interest to warrant a separate meeting. Prior to the meetings, ER&A staff met with the Project Officer and industry Consultants to prepare for the presentation of experimental activities to the suppliers. The following agenda details topics covered during the supplier sessions, although many other questions relating to the operation of the Medicare program were discussed by all parties concerned. Copies of the Sales Agreement and the Rental/Purchase Conversion Agreement (which were drafted by the legal Consultant to the project and reviewed by the DHEW Office of General Counsel, the Project Officer, ER&A, the industry Consultants and representatives of the carrier) were made available in quantity to the suppliers at these meetings. Copies of the final version of these agreements follow. It was felt that the experiment met with acceptance by suppliers who were present although the issue of currency of the charge screens from the standpoint of the supplier will always affect the manner in which they deal with Medicare beneficiaries. Some seemed enthusiastic about the experiment; particularly with the program's new ability to make a lump-sum payment for purchase of DME. In general, the ER&A staff felt that the supplier meetings, which covered a myriad of details about Medicare, in conjunction with mailings about the experiment by the carrier, would provide clarification and much needed information about the operation of the program. Copies of the Sales Agreement and the Rental/Purchase conversion were made available to the suppliers at these meetings.

AGENDA

for

Supplier Meetings

in

Spokane, Washington 10/25/77

Seattle, Washington 10/28/77

10:00 a.m.

- I. Opening Remarks
Mr. Pat Anunsen - Washington Physicians Service
- II. Legislative and Administrative History
Mr. Ted Saffran - Health Care Financing Administration
- III. The Experimental Reimbursement Options
Mr. Libert Ehrman - Exotech Research & Analysis, Inc.
- IV. Submission of Claims
Mr. Pat Anunsen

LUNCH

- V. Remarks by Supplier Consultants
Mr. Marvin Levand and Mr. Edward Roseman
- VI. Question and Answer Period

SALES AGREEMENT

FOR NEW OR USED EQUIPMENT
FOR MEDICARE BENEFICIARIES

DATE _____

CONTRACT NO. _____

BUYER: _____
 name _____
 street address _____
 city _____ state _____ zip code _____
 phone _____
 DELIVER TO: _____

SELLER: MEDICARE NO. _____
 NAME AND ADDRESS: _____

DME DESCRIPTION AND CLASSIFICATION CODE	ASMT TAKEN	MED. CERT (months)	SALES PRICE	
			NEW	USED

MEDICARE MAY PAY ALL OR PART OF THE COST TO RENT OR BUY
 MEDICAL EQUIPMENT. SEE REVERSE SIDE OF THIS CONTRACT
 FOR MORE INFORMATION ON YOUR RENTAL OR PURCHASE CHOICES.

I PURCHASED THE ABOVE EQUIPMENT SUBJECT TO THE TERMS
 LISTED BELOW.

X _____
 Buyer's Signature

SUBTOTAL	
DELIVERY	
OTHER CHARGES SPECIFY:	
SALES TAX	
TOTAL PRICE	

TERMS

1. Inspection. Buyer and Seller have each carefully inspected the equipment and found it to be suitable for his or her needs.
2. Passage of title. Title to the equipment shall pass to Buyer when Seller has received full payment of the Total Price, at which time Seller will mail or otherwise provide to the Buyer a copy of this contract marked "paid". This marked copy will evidence Buyer's ownership of the equipment.
3. Warranties.
 - a. New Equipment. Express warranties on new equipment are made only by the manufacturer. Seller shall make the terms of the warranty available to prospective purchaser prior to sale as required by the Magnuson-Moss Warranty Act of 1975.
 - b. Used Equipment. A FULL 90-DAY WARRANTY is made by the Seller on used equipment. For 90 days after purchase, Seller warrants that the above-described equipment will be free from defects in workmanship and materials which cause it to fail in normal usage. In the event of a defect or malfunction, Seller, shall, after receiving notice of such defect, repair or replace the equipment, or refund the purchase price, at Seller's option. Repair or replacement shall be without charge to Buyer. This warranty gives you specific legal rights, and you may also have other rights which vary from state to state.

Present Medicare reimbursement methods as of October 30, 1977 and continuing until changed are:

- o Monthly for rentals
- o Lump-sum for purchased items costing \$50.00 or less
- o Monthly installment payments for more expensive items that are purchased.

New payment methods (for the period October 31, 1977 - October 30, 1979) in addition to those above are:

- o PURCHASE OF NEW EQUIPMENT -

If your doctor prescribes a period of medical need long enough to justify a lump-sum payment for new DME, you will receive the amount for which Medicare is responsible in one payment.

- o PURCHASE OF USED EQUIPMENT -

If your doctor prescribes a period of medical need long enough to justify a lump-sum payment, you will receive the amount for which Medicare is responsible in one payment. In addition, you will not have to pay the usual 20% coinsurance if the price of the used DME is 75% or less than the Medicare allowed amount for comparable new equipment.

- o RENTAL/PURCHASE AGREEMENT FOR NEW EQUIPMENT -

You can rent new DME with the option to purchase it at a later date. When you exercise the option to purchase, the purchase price will be reduced as follows:

- a) If you exercise the purchase option within the first six months of rental, you will be given a discount equal to one month's rental fee.
- b) For each month of rental after 6 months an additional 2% of the purchase price will be discounted (up to a total of 2/3 of the purchase price).

The purchase price and rental charges must be established at the time you initially make the rental/purchase arrangement with your supplier. A lump-sum payment of the amount for which Medicare is responsible will be made when the purchase option is exercised, if the period of medical need is long enough to justify it at that time.

- o RENTAL/PURCHASE AGREEMENT FOR USED EQUIPMENT -

You can also rent used DME with the option to purchase it at a later date under the terms for new equipment described above. The 20% coinsurance will be waived if the price at the time of purchase is 75% or less than the Medicare allowed amount for comparable new equipment.

For any lump-sum purchase payment to be made by Medicare, your physician must prescribe the equipment for a long enough time so that the total rental cost would be more than the cost of purchase.

RENTAL/PURCHASE CONVERSION AGREEMENT

OPTION TO BUY ITEMS BEING RENTED AND
SALE AGREEMENT FOR EXERCISE OF OPTION

DATE _____

AMENDMENT TO
CONTRACT NO. _____

CUSTOMER:	SUPPLIER:
name	MEDICARE NO. _____
address	NAME AND ADDRESS:
city state zipcode	
phone	
DELIVER TO:	

OPTION TO BUY: Customer may buy DME being rented at any time during rental period if all rental fees owed have been paid. (Medicare Claims submission must be prior to October 30, 1979.)

CREDIT FOR RENT PAID: Supplier will give credit for rental as follows: (1) If purchased during the first six months of rental, rental credit is one month's rental fee; (2) If purchased after six months of rental, rental credit is one month's rental fee plus 2% of original purchase price for each month rented after six months; (RENTAL CREDIT WILL NOT EXCEED 66-2/3% OF ORIGINAL PURCHASE PRICE).

(TO BE COMPLETED AT TIME OF RENTAL)

DME DESCRIPTION AND CLASSIFICATION CODE	ASMT. TAKEN	MED. CERT. (months)	MO. RENTAL RATE	SALES PRICE	
				NEW	USED

(TO BE COMPLETED AT TIME OF SALE)

MEDICARE MAY PAY ALL OR PART OF THE COST TO RENT OR BUY MEDICAL EQUIPMENT. SEE REVERSE SIDE OF THIS CONTRACT FOR MORE INFORMATION ON YOUR RENTAL OR PURCHASE CHOICES.

I PURCHASED THE ABOVE EQUIPMENT SUBJECT TO THE TERMS LISTED BELOW.

☒ X Buyer's Signature _____ Date _____

SUBTOTAL	
DELIVERY	
OTHER CHARGES SPECIFY:	
SALES TAX	
TOTAL PRICE	

TERMS

- Inspection. Buyer and Seller have each carefully inspected the equipment and found it to be suitable for his or her needs.
- Passage of title. Title to the equipment shall pass to Buyer when Seller has received full payment of the Total Price, at which time Seller will mail or otherwise provide to the Buyer a copy of this contract marked "paid". This marked copy will evidence Buyer's ownership of the equipment.
- Warranties.
 - New Equipment. Express warranties on new equipment are made only by the manufacturer. Seller shall make the terms of the warranty available to prospective purchaser prior to sale as required by the Magnuson-Moss Warranty Act of 1975.
 - Used Equipment. A FULL 90-DAY WARRANTY is made by the Seller on used equipment. For 90 days after purchase, Seller warrants that the above-described equipment will be free from defects in workmanship and materials which cause it to fail in normal usage. In the event of a defect or malfunction, Seller, shall, after receiving notice of such defect, repair or replace the equipment, or refund the purchase price, at Seller's option. Repair or replacement shall be without charge to Buyer. This warranty gives you specific legal rights, and you may also have other rights which vary from state to state.

Present Medicare reimbursement methods as of October 30, 1977 and continuing until changed are:

- o Monthly for rentals
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New payment methods (for the period October 31, 1977 - October 30, 1979) in addition to those above are:

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If your doctor prescribes a period of medical need long enough to justify a lump-sum payment for new DME, you will receive the amount for which Medicare is responsible in one payment.

o PURCHASE OF USED EQUIPMENT -

If your doctor prescribes a period of medical need long enough to justify a lump-sum payment, you will receive the amount for which Medicare is responsible in one payment. In addition, you will not have to pay the usual 20% coinsurance if the price of the used DME is 75% or less than the Medicare allowed amount for comparable new equipment.

o RENTAL/PURCHASE AGREEMENT FOR NEW EQUIPMENT -

You can rent new DME with the option to purchase it at a later date. When you exercise the option to purchase, the purchase price will be reduced as follows:

- a) If you exercise the purchase option within the first six months of rental, you will be given a discount equal to one month's rental fee.
- b) For each month of rental after 6 months an additional 2% of the purchase price will be discounted (up to a total of 2/3 of the purchase price).

The purchase price and rental charges must be established at the time you initially make the rental/purchase arrangement with your supplier. A lump-sum payment of the amount for which Medicare is responsible will be made when the purchase option is exercised, if the period of medical need is long enough to justify it at that time.

o RENTAL/PURCHASE AGREEMENT FOR USED EQUIPMENT -

You can also rent used DME with the option to purchase it at a later date under the terms for new equipment described above. The 20% coinsurance will be waived if the price at the time of purchase is 75% or less than the Medicare allowed amount for comparable new equipment.

For any lump-sum purchase payment to be made by Medicare, your physician must prescribe the equipment for a long enough time so that the total rental cost would be more than the cost of purchase.

November 1977

The major activities during November included continuing assistance in support of Washington Physicians Service subsequent to their initiation of the experiment and planning for implementation with Occidental Life of California. Also, efforts were continued to obtain history tapes from all the participating carriers. Late in October an event occurred which had considerable impact on the operation of the project. This event was the passage of the Medicare-Medicaid Antifraud and Abuse Amendments (P.L. 95-142). Section 16 of this Amendment provided for changes in the reimbursement for DME as described below. A meeting was scheduled for early December between the Medicare Bureau Offices of Program Operations and Program Policy, the HCFA Office of Policy, Planning and Research and ER&A to discuss the impact of this legislation on the experimental project. The Principal Investigator travelled to Philadelphia, PA to give a presentation concerning the experiment to the Board of Directors and general membership of NADMEC during a meeting in which legislative changes made by P.L. 95-142 were being discussed.

Several days of meetings were held at Occidental Life of California in Los Angeles to allow the Principal Investigator to both review completed preparations for the experiment and present various aspects to those staff who were not as yet involved. Essentially, progress had included systems design work to allow for the alternative reimbursement mechanisms and the scheduling of meetings to discuss actual implementation of the experiment. A tentative date of March 1, 1978 was set for the implementation of the experiment.

On November 14 and 15, 1977 a Board of Directors and general membership meeting of the National Affiliation of Durable Medical Equipment Companies was convened in Philadelphia. The purpose of the meeting was to discuss legislative changes made by Section 16 of P.L. 95-142 (mandating purchase of DME in certain circumstances with reimbursement on a lump-sum or lease-purchase basis) and to formulate a position which NADMEC could present to the Medicare Bureau. Representatives were present from the New York Surgical Trade Association, the American Surgical Trade Association, the American Rental Association, the South Carolina and Florida Affiliations of DME Dealers and several independent suppliers. The first day was consumed by presentations of various proposals for lease-purchase plans, further legislative changes and the like. Following much discussion, the consensus was that any lease-purchase agreement should be governed by a clear, standard contract. Most of those present endorsed the idea that equipment should be divided into three categories:

- (1) inexpensive equipment (costing less than \$50-\$75) which should always be sold;
- (2) high-service equipment (such as life-support or respiratory equipment) which should always be rented; and
- (3) medium-priced or low-service items which should be either sold or rented as the need indicates.

Most of those present thought they could accept assignment for sales involving lump-sum payments for equipment and lease-purchase arrangements where title passed after at least 180% of the retail list price had been paid. Suggestions that rental rates, if inherently reasonable, be made uniform throughout the U.S., were opposed by many suppliers who preferred the locality basis. Most felt that the

patient should be entitled to rent the equipment until such time as he was instructed by the carrier to enter into some type of purchase agreement. The recommendations that were decided upon by the NADMEC membership were presented to the Medicare Bureau on November 16, 1977.

Although P.L. 95-142 was passed in late October, the amendment made by Section 16 applied retrospectively to October 1, 1977. Section 16 stated:

(a) Section 1833 (f) of the Social Security Act is amended to read as follows:

"(f) (1) in the case of durable medical equipment to be furnished an individual as described in section 1861 (s) (6) the Secretary shall determine, on the basis of such medical and other evidence as he finds appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants a presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump-sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it. (2) With respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable equipment. (3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medical equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible. (4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under this title on a lease-purchase basis whenever possible. (b) The Amendment made by subsection (a) shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977."

The Medicare Bureau interpreted Section 16 as superceding the experimental conditions and objectives and as a result concluded that the experimental effort should not proceed further. The Bureau did indicate, however, that the portion of the project in which the development of an appropriate data base was being undertaken was sufficiently important to warrant continuance. They asked that members of the Office of Program Operations and the Office of Program Policy meet with appropriate staff of the Office of Policy, Planning and Research to discuss the matter and the possibility of agreement on this approach. A meeting was scheduled in early December to this end.

December 1977

Probably the most important aspect of work concerning the project this month was the meeting referred to above. However, support of Washington Physicians Service and Occidental Life of California continued. In addition, ER&A began to receive copies of the Beneficiary History Files from the participating carriers. Documentation to allow for the extraction of DME claims information was also received. A major project subtask involving the construction of a classification methodology correlating the procedure code systems of the carriers (all of which were quite different) was begun.

A meeting was held on December 6, 1977 at the Medicare Bureau in Baltimore for the purpose of discussing both the DME experiment and the the implementation of Section 16 of P.L. 95-142. The Project Manager outlined the complexity of the DME Portion of Medicare and indicated that the expertise gained during the protocol development, start-up and implementation phases of the DME

experiment could be helpful in assisting the Medicare Bureau with the implementation of Section 16 of P.L. 95-142. Also pointed out were possible problem areas arising from differing interpretations of the new law. Each point in the outline which follows was discussed. The following recommendations for the Medicare Bureau were offered: allow the experiment to continue operation in some areas of the U.S.; compare experiment data to data collected in states implementing Section 16; and set up a monitoring program for the implementation of the new provisions of P.L. 95-142. The Project Officer offered the services of both OPPIR-ODE and ER&A to assist with the implementation of Section 16 of P.L. 95-142. During the meeting it was noted that Occidental Life of California was still preparing to implement the experiment on March 1, 1978. It was further noted that Occidental was having considerable success with the provision of computer programs to automate the claims processing alternatives to be utilized during the experiment.

Later in the month the Medicare Bureau issued a memorandum which concluded that the experimental contract should be terminated and the project brought to a conclusion. An approach was stated which would allow for Washington Physicians Service to comply with the regulations and general requirements to be issued as a result of Section 16. Further, it indicated that after due consideration, no other carriers should be allowed to operate under the experimental mode. Review of activities and evaluation of the experience with Section 16 was seen as outside the effort of the present contract. The memorandum concluded that the deliverables, research results, data accumulated and advisory expertise offered by

DME OUTLINE

1. Writing Regulations
 - a. Publish in the Federal Register
 - b. Respond to comments
 - c. Revise regulations
 - d. Publish final regulations
2. Developmental Stage
 - a. Systems design
 - b. Clerical design
 - c. Documentation - Systems and Clerical
 - d. Professional Relations information
 - e. Manual for District Office
3. Define "Financial hardship"
 - a. By default - the appeals process
 - b. By rigorous definition
4. Define "medical and other evidence"
 - a. Psychological
 - b. Physical
5. Consider the wording "in accordance with agreements with suppliers"
6. Relationship with Medicaid
 - a. Definition
 - b. Operations including actual payment systems
7. Reimbursement procedures (rent, purchase, lease-purchase)
 - a. Legal aspects
 - b. Operational definitions and characteristics
 - c. Systems implications
8. Implementation
 - a. Training of computer programming personnel
 - b. Systems testing
 - c. Training of claims processing personnel
 - d. Training of District Office personnel
 - e. Printing and other publication of public and professional information bulletins (Regional Offices, District Offices, carriers, suppliers, physicians, beneficiaries, media - newspapers, television, radio, etc.)
 - f. Meetings with suppliers
 - g. Start-up time
 - h. Implementation date

MONITORING THE DME PROGRAM

9. Cost of operations
 - a. Hand processing prior to full computer operations
 - b. DME claims processing is at least twice as costly as non-DME claims processing
 - c. Hand processing for an interim period is likely to cost two to four times the normal cost
 - d. DME claims are thought to be about two percent of benefit dollars
 - e. DME claims are about five percent of total claims
 - f. Delays and greatly increased administrative costs
 - g. Appeals and Congressional inquiries
10. Implication of reimbursement expenditures in first year
 - a. Medicare
 - b. Medicaid
11. Total costs to DME Program
 - a. Reimbursement total
 - b. By type of DME
 - c. By carrier
 - d. Administrative costs
 - e. Over time
 1. History
 2. Currently
 3. Projection
12. Future recommendations for procedures and legislation
 - a. Freedom of choice; experiment in some places
 - b. Compare experience of experiment with implementation of P.L. 95-142
13. Monitoring the DME Program
 - a. No requirements from the Medicare Bureau

the contractor and the Project Officer at the previous month's meeting could be made available to the Medicare Bureau, coincidental with the termination of the contract which was recommended to occur in several months. It must be noted that OPPR-ODE did not necessarily concur with this position inasmuch as the project was specifically mandated by the Congress. Additionally, the research results which were only beginning to become available with the initiation of data processing activities by the contractor were viewed as having considerable value in terms of establishing a baseline of information regarding DME.

Other activities during the month included receipt and log-in of tapes from Group Health Incorporated and The Travelers Insurance Company.

January 1978

Work in January changed somewhat in focus from the previous months. Initial processing of the tapes which had been received was begun. The Principal Investigator traveled to Seattle, WA and Los Angeles, CA to review experiment activities in Washington and assist in the planning for implementation in California. ER&A staff worked closely with the Project Officer on a number of position papers regarding various aspects of the experimental effort and its relationship to Section 16. In addition, a legal memorandum submitted to the Medicare Bureau and the DHEW Office of General Counsel by the American Rental Association was received and reviewed. History tapes were received from Occidental Life of California.

Meetings were held at the offices of the King County Medical Blue Shield in

Seattle, WA to review operation of the experiment. It was learned that the DME Subsystem was not yet functioning in totality and that manual processing of portions of the DME claims was still taking place. Also, the programming effort necessary to automatically provide a tape of the diary history was not as yet functional so an interim solution of providing ER&A with an ordinary history tape was discussed. In conversations with the Washington Physicians Service this topic was also broached and agreed to. Shipping of the two-year history tapes was to be made shortly.

Several days of meetings were held with staff of Occidental Life of California to schedule activities which must take place prior to the implementation of the experiment. These activities included mailings to suppliers, beneficiaries and physicians as well as meetings with suppliers. It was felt that five supplier meetings would allow for adequate coverage of the Occidental service area. Times were chosen and meeting rooms were secured for this purpose. In addition, the public information material actually used by the Washington Physicians Service was provided to Occidental and with few changes was considered appropriate for use. Mailings of this material were scheduled to take place during the months of February, March and April.

Upon returning to ER&A headquarters, the Principal Investigator informed the Project Officer of these scheduled activities. At this time, the HCFA decided to put Occidental Life in a "hold" status pending a decision with regard to the position taken by the Medicare Bureau. This action effectively eliminated the possibility of Occidental Life implementing the experiment on March 1, 1978.

February 1978

Data processing activities consumed the majority of project effort during February. In addition to those received already, tapes were received from Equitable Life Assurance Society relating to their four service areas. Data concerning the 1977 experience in Tennessee was not available, however.

Inasmuch as the tapes received were copies of the entire Beneficiary History File, efforts were undertaken to begin extraction of the appropriate DME claims from the years 1976 and 1977. A necessary first step was the compilation of a master procedure code listing which integrated the numerous differing classification schemes of the carriers. (This listing is contained in APPENDIX N.) In addition, production and retention of two tape sets was undertaken immediately upon receipt of each batch of tapes. Subsequent to extraction of the DME data, a set of preliminary tables was prepared to provide a preliminary summary of DME reimbursement. During data processing, continuing, close contact with the carriers was extremely important as the documentation of the procedure code systems often did not agree with the extracted information.

During the month also, Secretary Califano of the DHEW received a letter from Congressman Newton I. Steers, sponsor of the legislation which resulted in Section 16, P.L. 95-142. This letter indicated that "The Congress was explicit in not rescinding Section 245 of P.L. 92-603 which provides for 'reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment.' "

The letter continued with six specific areas of inquiry as follows:

- "1. Since I believe the experiment should be given a fair chance to develop reliable information on a national basis, are any states in addition to Washington and California to be included in the DME experiment?
2. I believe it is essential that the study under P.L. 92-603 should provide an analysis of the results of experimental reimbursement and administrative costs and that these results should be compared with information for an appropriate prior period so that changes in reimbursement patterns over time are made clearly evident.
3. In addition to obtaining the results of the experiment, I believe it would also be of value to the Congress to have a comparison of historical data and data collected from other states operating under new legislation (Section 16 of P.L. 95-142).
4. Since the success of new reimbursement methods may hinge on the extent to which beneficiaries, physicians and suppliers are informed and gain the requisite understanding of new alternatives, it is my belief that an intensive information campaign will be essential. My office has already been contacted by my constituents on this subject.
5. For low income citizens, state Medicaid programs may have a role in reimbursement for durable medical equipment. For this reason, for the states involved in the experiment and also those in which Section 16 is being implemented, close coordination with state Medicaid officials seems essential.
6. I am also concerned about what plans have been made for utilization of the results of the DME experiment in shaping reimbursement policies, and any subsequent Department recommendations to the Congress regarding improvements in future DME legislation so that we gain the maximum benefit from both the experiment and experience with the new law."

The letter concluded with a request that both Mr. Steers and Chairman Rostenkowski of the House Ways and Means Subcommittee on Health be kept informed concerning DME reimbursement experience and research results.

March 1978

Activity during March consisted mainly in data collection, computer programming and tabulation activities. ER&A received tapes from Washington Physicians Service, Group Health Incorporated and The Travelers Insurance Company. Work also continued, as it would for some time, on the master procedure code list. An informal briefing session was held with the Project Officer, the Principal Investigator and staff of the Office of Reimbursement Practices to discuss both the substantive issues under investigation in the experiment as well as the type of data being generated by the project. It must be noted that Occidental Life of California was still in a "hold" status awaiting a decision by HCFA as to implementation of the experiment.

April 1978

Data processing activities relating to collection and extraction of DME claims continued. More tapes were received from the Washington Physicians Service containing historical information. Also, efforts continued to synchronize the master procedure code listing with the summary data being compiled. Preliminary summary tabulations were produced and reviewed by the project team. Again, it must be noted that Occidental Life of California continued in a "hold" status pending a decision by HCFA to implement the experiment.

May 1978

Several important events occurred during May. The first was a response by Mr. Robert A. Derzon, Administrator, HCFA, to the letter of Congressman Steers

which indicated that "We are proceeding with the implementation of Section 16 and are continuing our experimental effort under Section 245 as noted below. Our response to your specific questions are provided below.

1. The State of Washington (Washington Physicians Service) has been paying claims under the experiment since October 1977. A rental-purchase arrangement is included in this reimbursement alternative. Implementation at Occidental Life of California has been deferred, pending the development of a lease-purchase alternative for testing. We do not anticipate expansion of the demonstration to other sites since we believe Washington and California will provide the necessary data to assess the alternate reimbursement systems under scrutiny.
2. With respect to analyses of DME data, our evaluative activities will assess the impact of the experimental systems on both administrative costs and reimbursement patterns over time.
3. We plan to obtain data from other States operating under Section 16 when the new procedures have become effective. Assuming these data become available within the period of the present experiment we will include them in our comparisons. If not, we will make a comparison retrospectively.
4. Concerning the need for public information, a special effort is being made under the experiment to promote public understanding. Large scale special mailings are made to beneficiaries, physicians, and suppliers. These describe the experiment in detail. Additionally, meetings with suppliers are held throughout the area affected. The regional office also makes announcements to the press and the district offices are informed so that they can respond to questions. With respect to section 16, the Medicare Bureau is developing a pamphlet to explain the new provisions. This pamphlet will be furnished to Social Security Offices, Part B carriers, and DME suppliers. Press releases are also being developed which will inform beneficiaries of both the provisions of the new law and the availability of the pamphlet.
5. On the subject of coordination with Medicaid: Medicaid programs vary from state to state. Variations are also found in coverage and reimbursement for DME. Information concerning both the experiment and P.L. 95-142 is being provided to the Division of Policy and Standards, Medicaid Bureau, HCFA. Through this mechanism the states will obtain the necessary information concerning both programs.
6. The results of our experimental effort and the experience gained under the new legislation will be fully analyzed and considered as new policy recommendations and operating procedures are developed."

Mr. Derzon indicated further that he was aware of the first analytical report to be issued by the contractor in August 1978 and stated that the Congressmen would be kept informed of DME related activities.

Somewhat later in the month, the contractor was requested by the Project Officer to participate in a meeting with staff of the Medicare Bureau to discuss the implementation of Section 16. In particular, discussion focused on lease-purchase arrangements as mentioned in that mandate. Those present were briefed on the current status of the experimental effort. In addition, ER&A staff had prepared some thoughts on the subject of lease-purchase agreements and these were discussed. The Medicare Bureau presented materials to the ER&A staff and the Project Officer concerning recommendations made by supplier and industry groups. ER&A was requested to review the materials and propose how to go about testing a lease-purchase alternative in California. It was agreed that both the contractor and the Project Officer would assist in such an effort.

During the month, also, data collection and tabulation activities continued. Additional tapes were received from Group Health Incorporated. This submission completed the set of historical data tapes from the carriers. The discrepancies noted earlier relating to the procedure codes were determined to be more widespread than originally thought and continuing contact with the carriers was necessary to ensure that correct claims were being extracted from the tapes of the entire Beneficiary History Files.

Occidental Life of California was informed of the general nature of the meeting which took place earlier in the month between ER&A, the Project Officer and the Medicare Bureau and plans were made to visit their headquarters in Los Angeles, CA to discuss their participation.

June 1978

During June ER&A reviewed the materials furnished by the Office of Policy relating to the implementation of Section 16. Several working sessions were held with staff and the Project Officer to discuss the various proposals made to the Medicare Bureau by supplier groups. In addition, the Principal Investigator contacted and visited several leasing companies with a view toward soliciting their opinions concerning alternative reimbursement mechanisms with potential for experimentation. These efforts were focused on the preparation of a position to be presented to the Medicare Bureau in the near future. Data tabulation and analysis activities also continued. Follow-up activities with all the carriers proved necessary to complete the integration of the procedure code systems.

July 1978

Activities in preparation of the First Interim Report to be issued by the project were clarified during July. Tabulations to be included and topics to be discussed were formalized. Data processing activities were stepped up to meet the deadline set for the delivery of the report in August 1978.

In the middle of the month ER&A staff again met with staff of the Office of Policy, Medicare Bureau to discuss the details of a lease-purchase arrangement

that might be considered an implementation of Section 16. The Principal Investigator provided an overview of the leasing industry and the applicability of their type of business to the Medicare program. The lease-purchase plan devised by the contractor and the Project Officer for experimentation was then discussed. The salient characteristics of the arrangement are contained on the following page. It was noted several times that there were legal and operational difficulties with the concept of lease-purchase in the context of the Medicare program, however, it was decided that the contractor and any staff of the agency which might be available would proceed to schedule a meeting with Occidental Life of California in order to solicit their cooperation in the proposed effort. The importance of on-sight support from Medicare Bureau Central Office was stressed by ER&A.

August 1978

Activity during the month of August consisted primarily of data processing, analysis and writing in preparation for the delivery of the First Interim Report at the end of the month. In addition, planning for the implementation possibilities of a lease-purchase experiment with Occidental Life of California was undertaken. A meeting between Occidental Life, ER&A, OPPI and the Medicare Bureau to discuss implementation was set for early September.

LEASE-PURCHASE EXPERIMENTAL ALTERNATIVE

- I. Conditions necessitating a lease-purchase agreement
 - A. Medical necessity of three months following a rental period of no more than three months.
- II. Terms of lease-purchase agreements
 - A. Lease-purchase agreements will be written for a twelve month period.
 - B. Equal monthly lease payments at 10 percent of the allowed purchase price will be made, culminating in purchase with no additional payment.
 - C. A penalty payment will be made if the beneficiary wishes to break the lease prior to the purchase transaction. The penalty will be equivalent to one monthly lease payment. The lease cannot be broken in the twelfth month, rather, the final payment will be made and title will pass to the beneficiary.
- III. Initial rental period
 - A. An initial rental period of three months will be allowed so that the beneficiary may file a claim and await its adjudication by the carrier. Presumably the carrier will notify the beneficiary as to the acceptability of his/her medical necessity statement and coverage of the DME. The carrier will then instruct him/her to enter into a lease-purchase agreement with a supplier.
- IV. Incentives
 - A. Supplier - Three months rental will be allowed followed by the 12 month lease-purchase. Therefore, fifteen months of payments could be collected. Based on 10 percent per month, it is likely that the supplier could receive 150 percent of the reasonable purchase price of the item. During the lease, services normally provided by the supplier in the case of rental may be billed separately, e.g. repair, etc.
 - B. Beneficiary - The beneficiary who in fact has a relatively long-term known medical necessity will be able to purchase the DME without having to pay the entire purchase price up-front and then wait to be paid monthly by Medicare, if at all.
 - C. Government - Situations of relatively long-term known medical necessity will result in the purchase of DME rather than long-term rentals.

September 1978

During September project staff met with staff of Occidental Life of California to discuss the possibility of a lease-purchase experiment. Other working sessions were held with both the Project Officer and members of the staff of the Medicare Bureau to discuss efforts towards mounting such an experimental effort. Meetings were also held with staff of the King County Medical Blue Shield to discuss various aspects of the data and experimental operations.

The meeting with Occidental Life of California opened with an explanation of the background activities of the Congress, the DHEW and the contractor relating to DME. Some details of the effort being undertaken in Washington, which had been planned for southern California were discussed, as a representative of the Regional Office who was not familiar with the project was present. No representatives were present from Central Office of the Medicare Bureau despite the efforts of the contractor to secure support from them in undertaking their own activities. Following this discussion, the need for an effort including a lease-purchase alternative as specified in Section 16 of P.L. 95-142 was discussed. Next on the agenda was an explanation of the details of the lease-purchase arrangement which had been previously discussed with staff of the Medicare Bureau. Discussion focused mainly on the role of the carrier, although all the participants in the experimental effort were considered. Questions of concern to the carrier were discussed relating to the mandatory nature of any such scheme with respect to beneficiaries and suppliers. In addition, the belief was expressed

that the lease-purchase mechanism might not provide any appreciable benefit to the beneficiary and might also create a major difficulty in the conduct of Medicare business with suppliers in the area. Additional questions concerning the actual operation of the experiment in general and the lease-purchase mechanism in particular surfaced. These questions related to computer, systems and clerical changes which would have to be made to accommodate a lease-purchase type reimbursement mechanism. It was noted that a somewhat different system from what was in place would have to be programmed to make the lease payments, which were to be a fixed percentage of the purchase price of DME. Existing systems had no provision for making a series of fixed payments. Another area of concern involved support for the effort. It was noted that the contract between HCFA and Exotech would expire in October 1979 but that the duration of the experimental effort might be longer, depending on the requirements of the Medicare Bureau. Support from both Central Office and the Regional Office would have to be forthcoming. Other questions were raised relating to the coordination of the effort with activities being undertaken by the Medicare Bureau. The carrier and the Regional Office representative were assured that the contractor was coordinating efforts with the Medicare Bureau Office of Policy and was in fact at Occidental at their request. It was stated that the results of this effort would certainly be helpful in defining any policy directive that resulted from Section 16.

Several days of meetings were held by the Principal Investigator at the offices of the King County Medical Blue Shield in Seattle, WA to discuss various aspects of the data furnished by the carrier to the contractor. In addition, a preliminary

indication of reimbursement with the experimental alternatives was given to the Principal Investigator. During the meetings the Principal Investigator and project Programmer/Analyst were able to make provisions for the receipt of further data concerning the experimental period and clarified numerous questions relating to the data already furnished.

In addition to discussions with the King County staff, the Principal Investigator met with representatives of the Regional Office in Seattle to discuss both the first Interim Report and the operation of the experiment.

Late in the month Occidental Life of California declined the solicitation to initiate an experimental lease-purchase program in their service area. This action was taken after considerable attention had been given by the carrier to the request. The contractor informed the Office of Policy within the Medicare Bureau of this decision, as did the carrier. Further, the contractor offered whatever support was required should the Medicare Bureau require assistance in implementing such an alternative elsewhere. Specifically, the contractor remained prepared to undertake the experimental effort should the Medicare Bureau select other carriers to be solicited for participation.

October 1978

Activity during the month of October consisted mainly of data editing and processing operations in support of the compilation of the second Interim Report to be issued in January 1979. In addition, preparations for various working

sessions held with the Medicare Bureau staff were undertaken as well as the sessions themselves. Preliminary review of incoming comments concerning the first Interim Report were initiated so as to analyze the inclusion of suggestions from the many reviewers. Several meetings were scheduled for early November.

November 1978

During the month of November primary efforts were devoted to continuing data processing and tabulation activities regarding the historical data from the various carriers. The Principal Investigator reviewed comments forwarded to the Project Officer by reviewers of the first Interim Report and planned for the inclusion of the majority in the second Interim Report. In addition, discussions between the Principal Investigator and various staff of HCFA were held to help guide the progress of the second report. Working sessions were also held with staff of the Medicare Bureau to familiarize them with the program statistics which resulted from the tabulation of data. The contractor was still awaiting a response by the Medicare Bureau regarding the lease-purchase experiment at the end of the month. Finally, the Principal Investigator was invited to attend a meeting of the HCFA-sponsored University Health Policy Consortium to be held in Boston early in December.

December 1978

Activity during the month of December consisted mainly of continuing data processing, editing and analytical activities in support of the preparation of the

second Interim Report to be issued in January 1979. Working sessions with staff of the OPPR-ODE were undertaken to finalize the contents of the report. Support for the initiatives of the Medicare Bureau continued relating to their efforts in the DME reimbursement area, however, planning for the operation of a lease-purchase experiment was curtailed. The Principal Investigator attended a meeting of the University Health Policy Consortium to assist in the planning of a research agenda for medical equipment and supplies.

January 1979

During the month the contractor's main effort related to the final preparation and issuance of the second Interim Report. Data processing and analytical activities by the project Programmer as well as the writing of the report by the Principal Investigator consumed the majority of the effort. The report was delivered to the Project Officer for review before printing and distribution. Additionally, the contractor continued to support the Medicare Bureau and to further that support resubmitted proposed modifications to the contract which were not contemplated at the outset of the project but which were at the request of the Medicare Bureau.

February 1979

Activity during the month of February was concerned mainly with revising and publishing the second Interim Report as well as planning for the third Interim and Final reports. Copies of the second Report were delivered to the Project Officer

for distribution and review. Copies were also distributed by the contractor to interested private and public parties throughout the country for review. Working sessions with the Medicare Bureau continued and culminated in the submission of proposed contract modifications to support Medicare Bureau initiatives dated February 28, 1979.

March 1979

Activity during the month consisted mainly of planning for travel and meetings by the Principal Investigator and Project Officer with Part B carriers, Part A intermediaries and Medicaid officials in the states and regional offices of HCFA. Preliminary lists of contact persons were developed and a preliminary itinerary including: Olympia and Seattle, WA.; Boise, ID.; and Sacramento and Los Angeles, CA. was developed. The tentative scheduling of travel to these locations was planned for late May 1979. Additional details relating to the proposed contract modifications were provided by the contractor and it was understood that the proposed modifications would satisfy the needs of the Medicare Bureau.

April 1979

Activity during the month consisted mainly of preparation for meetings with the carriers, intermediaries and state officials scheduled to be undertaken by the Principal Investigator. He also held meetings with staff of the Senate Finance Committee and the House Subcommittee on Health to provide details of the project and copies of the published Interim Reports. The Director of Medicare

Issues, ASPE, was also briefed concerning project activities. Compilation of data, tabulations and analysis activities continued toward the preparation of the third Interim Report due in July 1979.

May 1979

Activity during the month consisted mainly of travel and meetings with the Part B carriers, Part A intermediaries and state officials of Medicaid. The Principal Investigator and Project Officer traveled together and met with the following organizations: Blue Cross of Washington & Alaska; Department of Social and Health Services (Washington); Washington Physicians Service; Equitable Life Assurance Society; Blue Cross of Idaho; Department of Health and Welfare (Idaho); Department of Health Services (California); Occidental Life of California; and Blue Cross of Southern California. During these meetings details of activities relating to reimbursement for DME were discussed. The Project Officer typically opened each meeting with a brief description of legislative and administrative issues relating to DME. Then HCFA research activities to date were discussed. The Principal Investigator outlined results of the on-going research and demonstration project. The visitors then queried each host organization concerning policies and provisions for DME in the context of each program setting. In addition to the activities described above, tabulations and analyses were prepared for the third Interim Report to be completed in July 1979. During the month also, the contractor received the modifications agreement which allowed for the activities requested by the Medicare Bureau as described above. Visits to additional locations were planned for the following month.

June 1979

Activity during the month related to travel and meetings in a continuation of efforts begun in May. The Principal Investigator and Project Officer met with the following organizations together: The Travelers Insurance Company; Department of Social Services (New York); Blue Cross/Blue Shield of Richmond; and the Virginia State Health Department. The Principal Investigator visited Equitable Life Assurance Society, Group Health Incorporated Blue Cross/Blue Shield of Greater New York and the Region II Office of Program Integrity by himself on a trip to New York City. The latter organization was visited as it had been learned that they were undertaking some activities in the area of DME and had requested information from the Project Officer concerning the progress of the project. Meetings other than the latter took the form of those described in May 1979 above. The intent of the meetings was to discover the interface between the Medicare and Medicaid programs. In addition, activities continued toward the completion of the third Interim Report due in July 1979.

July 1979

During July, the Principal Investigator and Project Officer continued meeting with carriers, intermediaries and state Medicaid officials. These visits included: the Department of Human Resources (District of Columbia); The Travelers Insurance Company; Minnesota Department of Public Welfare; and Blue Cross/Blue Shield of Minnesota. The format of these meetings was essentially that described in May 1979. In addition, the third Interim Report was drafted and

delivered to the Project Officer for review prior to publication. Subsequently, the Report was distributed to those organizations and individuals who had requested copies from either the Project Officer or the contractor. Internal HCFA distribution by the Project Officer requested comments from the reviewers as had been the practice in the past. a memorandum to that effect and distribution list follow.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTHCARE FINANCING ADMINISTRATION

TO : See Below

DATE: AUG 30 1979

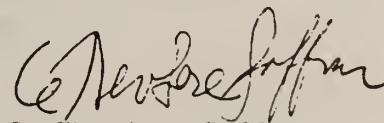
REFER TO:

FROM : Project Officer
Office of Demonstrations and Evaluations
Office of Policy, Planning and Research.

SUBJECT: Request for Review--Durable Medical Equipment (DME)

Attached is a copy of the third Interim Report from Exotech Research and Analysis. The data contained in this report have been compiled from the history files of five Part B carriers representing eleven geographic areas.

I would appreciate receiving any comments/suggestions that you may have on behalf of this project by September 17, 1979. Please forward your reviews to my office, Room 3-E-6, Meadows East Building, Baltimore, Maryland 21235. Thank you.


G. Theodore Saffran

Attachment

Addresses:
Please see attached sheet

ADDRESSEESMedicareRegional Office

Mr. J. Bedford - Atlanta
 Ms. S. Cassell - San Francisco
 Ms. D. Dosser - Seattle
 Mr. J. Isham - Denver
 Mr. G. McMahan - Dallas
 Mr. D. Mordy - Kansas City
 Mr. J. Polk - Philadelphia
 Mr. J. Sullivan - New York
 Ms. D. Vargas - Chicago
 Mr. D. Wilson - Boston

Medicare Resident Reps.

Mr. B. Childers - D.C. Medical
 Mr. B. Crockett - Travelers
 Mr. T. Cullen - Travelers
 Mr. P. Lowen - Metropolitan
 Mr. L. Platt - GHI
 Mr. P. Pasternak - Travelers
 Ms. C. Read - Occidental
 Ms. J. Thannisch - Equitable
 Ms. G. Weinreb - GHI
 Mr. B. White - Equitable

Medicaid State Reps.

Ms. M. Blume - Atlanta
 Ms. B. Butterfield - Seattle
 Mr. J. Dye - Chicago
 Ms. C. Nisnewitz - New York
 Ms. J. Walker - San Francisco
 Ms. T. Weiss - Philadelphia

Carriers

Mr. R. Arnold - Travelers
 Mr. C. Field - King County
 Blue Shield
 Mr. J. Ryan - GHI
 Ms. B. Sangetti - GHI
 Mr. P. Mills - Occidental
 Ms. M. Shadle - WPS
 Mr. E. Tateosian - Equitable

Medicaid State Agencies

Ms. M. DeBow - California
 Mr. F. Edwards - Mississippi
 Dr. R. Hall - Washington
 Mr. D. Johnson - Tennessee
 Dr. O. Merrill - Idaho
 Mr. G. Nelligen - New York
 Mr. M. Perkins - Virginia
 Mr. R. Randle - Minnesota
 Ms. M. Smith - Florida

Central Office

Mr. M. Dyer - BPP
 Dr. R. Egeberg - OSPA
 Ms. E. Jones - OLP
 Ms. H. Lazenby - OR
 Mr. W. Lutts - BPO
 Ms. L. Magno - OPA
 Mr. J. Patton - OPI
 Mr. N. Pigman - OR
 Ms. S. Ryan - BPP
 Ms. B. Schumaker - ORP
 Dr. R. Vogel - OR
 Mr. C. Warfield - OFAA

August 1979

During the month of August, activities were divided between meetings with carriers, intermediaries and state officials, a private Home Health Agency organization and a large private supplier. Additionally, preparations for an upcoming Advisory Panel meeting and a separate HCFA briefing were begun. Both of the latter meetings were scheduled for September 1979. Details of the latter meetings will be found under that title. The Principal Investigator and Project Officer met with the following: Sears Roebuck & Company; Upjohn Healthcare Services; Equitable Life Assurance Society; the Division of Medical Assistance (Tennessee); The Travelers Insurance Company; Blue Cross/Blue Shield of Mississippi; and the Mississippi Medicaid Commission. Extensive planning and preparation activities were also begun to assemble comments from the three Interim Reports as an aid to the production of the Final Report. During the month also, the Principal Investigator began writing the Report. It was decided that a draft of the Final Report would be delivered to the Project Officer on October 14, 1979. This draft would be distributed throughout HCFA and to the Advisory Panel for review and comment.

September 1979

Activity during the month began with meetings with Medicaid officials and GHI in Florida. In addition the Principal Investigator attended the National Convention of the American Surgical Trade Association in San Francisco. Two other meetings

of importance which took place during the month were the Advisory Panel meeting and the contractor's final briefing of HCFA. In preparation for these meetings an additional trip to Seattle, WA was taken. Other activities during the month included writing and editing of materials to be included in the Final Report by the Principal Investigator.

Several days of working sessions were held between the Principal Investigator and the Vice President of King County Medical Blue Shield. The purpose of these sessions was twofold. First, to discuss and prepare for terminating the experiment following its two-year operation in the state of Washington. Plans were made to inform beneficiaries, suppliers and physicians concerning the reimbursement alternatives available under existing legislation and regulations. Second, the Vice President, Mr. Clayton Field had been invited by the contractor to make a presentation at the HCFA briefing to be held in Baltimore. The presentation was designed to provide a view of the carrier's role in this research and demonstration project. Details are provided below.

Following are detailed reports of both the Advisory Panel meeting, held at the contractor's facility and the HCFA briefing held more conveniently to HCFA headquarters.

Advisory Panel Meeting
Exotech Headquarters
Gaithersburg, Maryland

September 19, 1979

A final meeting of the Advisory Panel was held on September 19, 1979 at the headquarters of Exotech Research & Analysis, Inc. in Gaithersburg, Maryland. Attendees included:

Theodore J. Janssen - Exotech Principal Investigator
G. Theodore Saffran - HCFA Project Officer
Irving Perkin - National Association of Blue Shield Plans
Teresa Napoli - American Association of Retired Persons
Edward Roseman - National Affiliation of DME Companies
Marvin Levand - American Rental Association

Other members of the Advisory Panel were unable to attend.

Mr. Janssen opened the meeting by welcoming all those present and explaining the nature and purpose of the Advisory Panel meeting. He indicated that a high level Advisory Panel was established for the project to offer guidance in carrying out various aspects of the project and to review materials published under the auspices of the project. It was noted that the Panel consists of representatives of suppliers, national supplier associations, the medical profession, organizations of the elderly and the carriers. Each of these constituent groups plays a key role in DME decision-making. The cooperation of these groups, along with the participating carriers, regional and central office HCFA staff was considered essential to the successful completion of the project.

The purpose of the meeting was then stated as follows: (1) to present the details of the project to the Advisory Panel members, particularly to those who had not previously been briefed on the project as a whole; (2) to present the data and information resulting from tabulations and analysis of the two-year data base of DME claims; (3) to discuss the setting, implementation, operation and results of the demonstration in Washington state; and (4) to solicit the comments and opinions of the various parties present regarding the project, collected data and information and preparations for the Final Report.

An explanation of the Experiment began with the review of the background and legislative history that led to the present Exotech contract effort. Pertinent major activities were noted as follows: (1) GAO Report; (2) 1972 Amendments, Section 245, P.L. 92-603; (3) Protocol Development Contracts; (4) House Ways and Means Oversight Subcommittee Report; (5) Experiment Contract; (6) Section 16 P.L. 95-142; (7) Resulting regulations from Medicare Bureau; and (8) Proposed Senate Bill 505.

During this presentation, discussion naturally focused on the alternative reimbursement mechanisms developed in the protocol. The various incentives thought to be operating with regard to these experimental alternatives were also described. Discussion focused next on the results from Washington state. These were summarized as follows: (1) lump-sum payment provisions eliminated virtually the entire backlog of diary claims in the carriers claims processing system; (2) whereas before the experiment 2.4% of the rental episodes were longer than one year and 10.6% of rental reimbursement was spent on them, during the experiment only .9% were longer than a year accounting for only 3.9% of rental reimbursement; (3) used equipment provisions seemed to have little popularity; and (4) rental/purchase provisions were not utilized.

Discussion of these general results continued in depth throughout the day. The small size of the sample on which these conclusions are based, being only the experience of Washington state, led several panel members to suggest that perhaps the experiment should be duplicated in other geographic areas. This point led to a detailed description of efforts undertaken by the project staff to enlist the support of HCFA Central and Regional Office personnel, carrier personnel and personnel of the National Association of Blue Shield Plans in the solicitation of carriers for the project. It was noted that the project had contacted nineteen carriers, including seven private carriers and twelve Blue Shield Plans. Of these only four private carriers and one Blue Shield Plan agreed to participate. It was further noted that the carriers had separate contracts with HCFA for the project so that activities undertaken on behalf of the project were not reflected in their regular costing and budgeting.

Geographic coverage of the project and solicitation efforts was pointed out on a map and statistics concerning the population covered by the project were discussed. This discussion led to a several-hour "walk-thru" by the Principal Investigator of the three Interim Reports resulting from the project. Numerous questions, comments and analyses were offered in explanation of tabulations. Members of the Panel were extremely helpful in reviewing the materials, providing input for the Final Report and indicating conclusions concerning the project from their own particular perspective.

HCFA Briefing
Holiday Inn - Belmont
Baltimore, Maryland

September 27, 1979

A briefing was held on September 27, 1979 to present a synopsis of the research and demonstration project which has been directed by Exotech Research & Analysis, Inc. over the last several years. A list of attendees is included, as well as a copy of the invitation letter and attached agenda.

Mr. Libert Ehrman, Exotech Project Manager, opened the meeting by welcoming all present and explaining the nature and purpose of the briefing. He provided introductory and background information with regard to the development of the Medicare program features which include durable medical equipment. He summarized the organization of the project internally as well as its external coordination with HCFA. Next was a description of early project efforts both before contract award (during proposal preparation) and after contract award of the experiment contract relating to the solicitation of carriers to participate in the project. Problems of implementation, particularly with regard to the activities of the Model B Systems group, were described. Touched upon also was the general lack of support by Central Office and Regional Office HCFA components, although exceptions to this general rule were noted. In fact, those who were most helpful during the project were acknowledged.

The Project Officer, Mr. G. Theodore Saffran, also welcomed the attendees and presented detailed information concerning the legislative and administrative history that occurred prior to and during the project. Of particular importance were references to the: (1) GAO Report; (2) 1972 Amendments, Section 245, P.L. 92-603; (3) Protocol Development Contracts; (4) House Ways and Means Oversight Subcommittee Report; (5) Experiment Contract; (6) Section 16 P.L. 95-142; (7) Resulting regulations from Medicare Bureau; and (8) Proposed Senate Bill 505. Additionally, Mr. Saffran presented an overview of general experimental requirements, including: (1) beneficiaries must have the freedom of choice in acquiring DME, by rental or purchase, regardless of supplier; (2) provision for the needed DME as long as medical necessity exists; and (3) potential for successful performance and acceptability in the marketplace.

The Principal Investigator, Mr. Theodore J. Janssen, then began a brief introduction to the reimbursement alternatives which were utilized in the experiment. Initially, several terms were defined which have been the cause of much confusion between Government and industry in the past. These terms included rent, purchase, lease, rental/purchase and lease-purchase. The three experimental procedures, lump-sum payment - no limit, used equipment provision and a rental/purchase provision were then outlined.

After a short coffee break, details of the three alternative procedures provided for in the experiment were described. Their applications, based on long-term need, deductible and co-insurance status, estimated period of medical necessity and other operational characteristics were explained. It was noted that, although relatively straightforward, the inclusion of these three basic alternatives resulted in a complex system of thirteen different methods of payment.

Following this brief description of the experimental effort, Mr. Clayton Field, Vice President, King County Medical Blue Shield, began his presentation of the role of the carrier in the project. Topics included in his presentation were: the view of a carrier regarding cooperation with experimental projects and background concerning the decision to cooperate in this project in particular; information campaign to reach beneficiaries, suppliers, physicians and other appropriate persons in the service area; coordination of objectives with the Regional Office; systems development, testing and implementation; training sessions for the education of claims processing and supervisory personnel; impact on the claims processing activities of the carrier in general; and general reaction to the implementation, operation and results of the demonstration.

After Mr. Field's presentation, questions were solicited from the audience. All speakers involved in the briefing responded to the inquiries.

Following lunch, Mr. Janssen continued with a lengthy description of the data collection, tabulation and analysis activities undertaken during the three-year project. He began with a statistical description of the SMI program enrollment throughout the participating carriers' service areas. These included: Equitable Life Assurance Society of the U.S. (Tennessee, New Mexico, Wyoming and Idaho); Group Health Incorporated (Florida and New York); Occidental Life Of California (California); The Travelers Insurance Company (Mississippi, Minnesota, Virginia); and Washington Physicians Service (Washington). These data were also presented in a manner that illustrated their distribution throughout the ten HEW Regions.

Next to be presented was a description of the development of a draft classification scheme for durable medical equipment that had been undertaken by Exotech during the protocol development period. The necessity for organizing such a scheme was apparent early on as each carrier maintains a different procedure code system for DME. In fact, some carriers utilize several different systems in their various service areas.

Upon initial review of the data, a revised scheme was developed to facilitate the presentation of data relating to generic categories of DME. Analysis of the data base of DME claims which were extracted from the 1976-1977 beneficiary history files of the five carriers indicated that the following categories might be considered appropriate for the compilation, tabulation and presentation of data

within these files. The final DME classification scheme is listed below:

- Hospital Beds and Accessories
- Commode Chairs, Bedpans, Urinals, and Toilet Accessories
- Canes, Crutches and Accessories
- Traction Equipment and Accessories
- Walkers and Walking Aids
- Wheelchairs and Accessories
- Oxygen
- Oxygen Therapy Equipment
- Pads and Cushions
- Repairs/Maintenance
- Miscellaneous DME
- Unspecified DME

These categories were described, and the necessity for splitting oxygen and oxygen therapy equipment, as well as the necessity for the inclusion of a category of unspecified DME was justified.

Reimbursement for durable medical equipment under the Part B Medicare program was the next topic of presentation. Total reimbursement, as well as a breakdown by rental and purchase of the categorical (cited above) expenditures, was presented in a series of vu-graphs. Estimates of total program expenditures based on the data derived from each of the five carriers were pictured next. Discussion of per capita costs and the numbers of DME users as a percent of SMI enrollment in the various carrier service areas followed.

At this point, a brief description of the reasonable charge process was given. Statistics were cited relating to denied claims, paid claims and legitimate but not paid claims (due to remaining deductible amounts).

Following the afternoon coffee break, Mr. Janssen continued with a description of activities relating to the investigation of the interface between Medicare (A & B) and Medicaid regarding DME. A brief overview of the wide variety of differences between these programs was given. Questions and comments concerning these topics were fielded from the attendees and answered. Mr. Janssen made the point of the variety of reimbursement alternatives and the depth of experience that exists with regard to DME in the State Medicaid programs which were visited during the operation of the project. Virtually every proposed methodology for reimbursement for DME has been attempted by the states. It was further noted that with the reorganization of HCFA, combining Medicare and Medicaid, the experience of the states should become more easily accessible to HCFA.

Differences between the Part B program and Part A were also described. Although DME is by statute a Part B benefit, oftentimes hospitals and home health agencies arrange and bill for DME. Hospitals typically bill under the category of outpatient services and

home health agencies often include requests for payment in the "Other" category. Frequently the DME is not identified either as to type or by mode of acquisition, i.e. rental or purchase. Very rough estimates of federal expenditures for DME in Part A and Medicaid are \$25 million annually and \$125 million annually, respectively. The Medicare Part B program was also estimated to reimburse approximately \$125 million in the same time period.

Upon returning to the description of the Part B program, several other details were discussed by Mr. Janssen. Assignment status, averaged length of rental episodes, distribution of rental reimbursement described by length of the episode, frequency distribution of reimbursement for DME and charge and expenditure relationships were illustrated. The relationship between submitted charges, denials, reasonable charge reductions, deductible payments and co-insurance payments was illustrated and provided for much discussion by the audience.

The last portion of Mr. Janssen's presentation dealt with the results of the demonstration project undertaken in Washington state. During this presentation, discussion naturally focused on the alternative reimbursement mechanisms developed in the protocol. The various incentives thought to be operating with regard to these experimental alternatives were also described. The results from Washington state were summarized as follows: (1) lump-sum payment provisions virtually eliminated the entire backlog of diary claims in the carriers claims processing system; (2) whereas before the experiment 2.4% of the rental episodes were longer than one year and 10.6% of rental reimbursement was spent on them, during the experiment only .9% were longer than a year, accounting for only 3.9% of rental reimbursement; (3) used equipment provisions seemed to have little popularity; and (4) rental/purchase provisions were not utilized.

Messrs. Saffran and Ehrman closed the meeting with general remarks concerning the project planning, implementation, operation and outcomes. Attendees were thanked for their participation and recommendations from the audience were solicited. A question and answer/discussion period ensued, in which legislative proposals and regulatory actions were covered. The briefing was adjourned by Mr. Ehrman.

Copies of the letter of invitation and the agenda as well as a list of attendees follow directly.

August 31, 1979

Dear

You are invited to attend a contractor briefing for interested agency personnel on the subject of durable medical equipment (DME) as related to the programs of the Health Care Financing Administration (HCFA). In accordance with our contractual effort for HCFA, we plan to present a synopsis of the research and demonstration project which we have directed over the last several years. The meeting will be held at the Holiday Inn - Belmont near the HCFA complex in Baltimore on September 27, 1979.

The enclosed agenda specifies the activities and arrangements which have been planned for the one day meeting. You will note that the schedule focuses on two principal areas. One is a presentation of the administrative, research and experimentation activities which relate to the experimental portion of the project. Details will be presented by the Project Officer, Mr. G. Theodore Saffran, the Project Director, Mr. Libert Ehrman, the Principal Investigator, Mr. Theodore J. Janssen and the Vice President of the King County Medical Blue Shield, Seattle, Washington, Mr. Clayton Field.

Subsequently, Mr. Janssen will outline basic quantitative and programmatic aspects of the DME portion of HCFA programs, including Medicare Part A and B and Medicaid which have been documented during the operation of the project. He will then present conclusions and recommendations derived from the study.

It is requested that you confirm your attendance at this meeting before September 18, 1979 as space will be limited to only those responding. Please call Ms. Carla Riley of our organization to do so.

We look forward to your participation in this briefing session.

Sincerely yours,

Libert Ehrman
Project Director

BRIEFING ON DURABLE MEDICAL EQUIPMENT

September 27, 1979

Holiday Inn - Belmont
1800 Belmont Avenue
Baltimore, Maryland 21235
(301) 265 - 1400

SCHEDULE

Introductory Remarks L. Ehrman	9:30 a.m.
Legislative and Administrative History T. Saffran	9:45 a.m.
The Experimental Effort L. Ehrman and T. Janssen	10:00 a.m.
Coffee Break	10:30 a.m.
The Role of the Carrier in the Project T. Janssen and C. Field	10:45 a.m.
Questions on the Experiment	11:15 a.m.
LUNCH	11:45 a.m.
The DME Portions of Medicare Part A and B and Medicaid Presentation of Findings T. Janssen	1:15 p.m.
Questions and Discussion	Throughout
Coffee Break	2:45 p.m.
Conclusions and Recommendations T. Janssen	3:00 p.m.
Questions and Discussion	Throughout
Closing Remarks L. Ehrman	4:00 p.m.

ATTENDEES AT HCFA BRIEFING

SEPTEMBER 29, 1979

EXOTECH RESEARCH & ANALYSIS, INC.

Libert Ehrman - Project Manager
Theodore J. Janssen - Principal Investigator
Robert G. Lyle - Systems Manager
J. Michael Talbot - Data Processing Specialist
Carla Riley - Administrative Assistant

HEALTH CARE FINANCING ADMINISTRATION

Fred Abbey - Office of Legislation and Policy
Mike Blank - Medicaid/Medicare Management Institute
Peggy Bowman - Bureau of Quality Control
Frank Chase - Bureau of Program Operations
Frank Eppig - ORDS, Office of Research
Judy Fischer - ORDS, Office of Research
Marla Frazier - Office of Standards and Performance Evaluation
Dave Gibson - ORDS, Office of Research
Dick Griffith - Bureau of Program Policy
Ron Gwyn - Office of Methods and Systems
Marti Happel - ORDS, Office of Research
Jim Hatten - ORDS, Office of Research
Ernestine Jones - Office of Legislation and Policy
Andrea Kelly - Office of Program Integrity, Region II
Grace Kennedy - Office of Reimbursement Policy
Pat Kohr - Office of Methods and Systems
Helen Lazenby - ORDS, Office of Research
Linda Magno - Office of Legislation and Policy
Vincent Mazzuca - HEW Audit Agency
August Papa - Bureau of Program Policy
John Polk - Philadelphia Regional Office
Joel Schaer - Office of Reimbursement Policy
Ed Trago - Bureau of Quality Control

CARRIER REPRESENTATIVES

Richard Arnold - The Travelers Insurance Company
Jerome Bibuld - Group Health Incorporated, New York
Clayton Field - King County Medical Blue Shield
Martin Haver - Blue Cross/Blue Shield of Greater New York
Peter Mills - Occidental Life of California
James Whitney - Equitable Life Assurance Society of the U.S.

OTHER ATTENDEES

John Bush - Minnesota Medical Assistance Program
Mead Over, Jr. - Williams College
Roberton Williams - Williams College

October 1979

Production of the draft Final Report was completed and copies were delivered to the Project Officer for review. A contract extension was granted to allow for inclusion of comments by the reviewers of the document. This extension provided for delivery of the completed Final Report on January 14, 1979. The Project Officer distributed the draft report to appropriate Office Directors and HCFA Regional Administrators for staff comment.

In addition to review by internal HCFA staff, the contractor requested review of the document by members of the project Advisory Panel.

These comments were forwarded to the contractor and taken into consideration in the preparation and publication of the Final Report.

CHAPTER III

THE EXPERIMENTAL ALTERNATIVES

DETAILS OF LUMP-SUM REIMBURSEMENT FOR NEW EQUIPMENT

The lump-sum reimbursement for a new item of DME (LSN) may be offered to those beneficiaries where long-term medical need has been established. Payment may be assigned to the supplier of DME who agrees to accept the reasonable purchase price as determined by the Part B carrier. If the supplier accepts assignment, the Medicare benefit payment amount will total 80% of the reasonable purchase price subject to the annual deductible. The remaining 20% of the reasonable purchase price (and the deductible, if applicable) is the responsibility of the beneficiary and may be paid in full or in part by Medicaid or another insurance plan. Title to the item of DME passes to the beneficiary when the reasonable purchase price has been paid to the supplier.

If the supplier does not accept assignment for LSN, the Medicare reimbursement to the beneficiary, subject to carrier approval of the claim, will total 80% of the reasonable charge for the item after the annual deductible has been met. The beneficiary is responsible for the difference between the Medicare reimbursement amount and the actual purchase price. Some portion of this difference could be reimbursed via Medicaid or another insurance plan. However, the beneficiary may still have an unpaid balance with the supplier. Suppliers are encouraged to provide a suitable arrangement with the beneficiary to meet his/her particular financial situation so as not to cause undue financial burden. Title to the item passes to the beneficiary when the financial obligation to the supplier has been satisfied.

Upon transfer of title, the supplier no longer has any obligation to provide services to the beneficiary other than services under warranties. Specifically, maintenance and repairs to the purchased item of DME are the responsibility of the beneficiary. Claims may be filed under Part B Medicare for partial payment for maintenance and repairs.

Expected Advantages of Lump-Sum Payments for New DME (LSN):

- Lower total administrative and billing costs since multiple payments are eliminated;
- Potential lower cost to beneficiary since excessive rentals are eliminated;
- Is acceptable to the suppliers who sell durable medical equipment;
- Potential elimination of a large majority of assignment refusals by suppliers; and
- Elimination of the monetary risks imposed by the present method on either the supplier or the beneficiary.

Potential Disadvantages of Lump-Sum Payment for New DME (LSN):

- Possible cost disadvantage to beneficiary who purchases when rental would have been cheaper, e.g., beneficiary unexpectedly recovers;
- Possible disadvantage to SSA if purchase decision is made when rental would have been cheaper, e.g., beneficiary recovers or dies;
- Disposal of DME owned by beneficiary or his estate after the period of use has passed; and
- Beneficiary is now responsible for the maintenance of the equipment.

DETAILS OF LUMP-SUM REIMBURSEMENT FOR USED EQUIPMENT

Lump-sum reimbursement for a used item (LSU) which the supplier is willing to sell may be offered where long-term medical need has been established, subject to the deductible and co-insurance. However, if the purchase price is at least 25% less than the reasonable charge for a similar new item, the 20% co-insurance is waived.

For purchases where the 20% co-insurance may be waived, payment may be assigned to the supplier of DME. The Medicare benefit payment amount will total no more than 75% of the reasonable purchase price of a similar new item of DME. The purchase price is subject to the annual deductible of \$60 by the beneficiary. The 20% co-insurance amount is waived, and the beneficiary owes nothing to the supplier, except, possibly, the deductible. Title to the used item of DME passes to the beneficiary when the reasonable purchase price has been paid to the supplier.

If the supplier does not accept assignment for purchases where the co-insurance may be waived, the Medicare reimbursement amount to the beneficiary, subject to carrier approval of the claim, will total no more than 75% of the reasonable charge for a similar new item, subject to the deductible. As the 20% co-insurance is waived, the reimbursement plus the deductible (if applicable) will total the actual purchase price of the used equipment. Title to the used item of DME passes when the beneficiary has satisfied his financial obligation to the supplier.

For purchase of used equipment where the co-insurance is not waived, the reimbursement procedures are the same as that previously described for purchases

of new equipment. Again, suppliers are encouraged to work out a suitable arrangement for the beneficiary to meet his/her financial obligation.

Upon transfer of title, the supplier no longer has any obligation to provide any services to the beneficiary, except for warranties. Specifically maintenance and repairs to the purchased item of DME are the responsibility of the beneficiary.

Claims may be filed under Part B Medicare for partial payment for maintenance and repairs.

Expected Advantages of Lum-Sum Payment for Used Equipment (LSU):

- No cost to the beneficiary if the co-insurance is waived;
- Lower total administrative and billing costs, since multiple payments are eliminated;
- Potential lower cost to beneficiary since excessive rentals are eliminated;
- Is acceptable to the suppliers of durable medical equipment;
- Potential elimination of a large majority of assignment refusals by suppliers; and
- Elimination of the monetary risks imposed by the present method of either the supplier or the beneficiary.

Potential Disadvantages of Lump-Sum Payment for Used Equipment (LSU):

- Possible cost disadvantage to beneficiary who purchases when rental would have been cheaper, e.g., beneficiary unexpectedly recovers;

- Possible disadvantage to SSA when purchase decision is made when rental would have been cheaper;
- Beneficiary is now responsible for the maintenance of the equipment;
- Possible multiple purchases by the beneficiary due to wearout and failure of used equipment; and
- Disposal of DME owned by beneficiary or his estate after the period of use has passed.

DETAILS OF DELAYED LUMP-SUM REIMBURSEMENT

Delayed lump-sum purchase reimbursement (DLS) and rental/purchase conversion for an item of DME may be offered to any beneficiary. The purpose of this reimbursement procedure is to allow a beneficiary to convert from rental to purchase of DME if a long-term need is established. The beneficiary who has a short-term or indeterminate medical need for DME acquires the DME by rental; however, if during the rental period his condition is diagnosed as long-term or his condition changes to a long-term medical need (subject to carrier approval of the claim) the beneficiary is now eligible to purchase the item of DME.

With the following rental/purchase conversion discounting procedures, Medicare reimbursement coincides in terms of reasonable purchase prices and rental fees. A rental item may be converted to purchase in the following manner: Suppliers will allow at least one month's actual rent as a discount to the conversion purchase price if the conversion is made during the first 6 months of rental. Beginning with the 7th rental month, and for each succeeding month thereafter,

an additional percentage (at least 2%) cumulative discount off the original selling price of the equipment is applied to the actual purchase price at the time of conversion, terminating with at least a 66 2/3 % discount off the original selling price whenever such discount is reached. The beneficiary will be allowed to purchase the item thereafter at this discount from the original selling price (price at the time of the initial rental), provided rental has been continuous.

For an item that has been approved by the carrier for rental and is being rented, Medicare reimbursement may be made in the form of a lump-sum payment (either DLSN or DLSU below) as described previously. There is no change from the present Part B procedures for rental reimbursement.

Payment for the delayed purchase of new equipment (DLSN) may be assigned to the supplier of DME. The Medicare lump-sum reimbursement amount paid to the supplier at the time of the conversion will total 80% of the following: the reasonable purchase price determination at the outset of rental less the discount and the deductible (if applicable). Again, the discount for reimbursement is at least one month's reasonable rental fee if the conversion occurs within the first 6 months of rental and, an additional percentage (at least 2%) of the original reasonable purchase price determination (at the outset of rental) for each month beginning with the 7th month of rental until such discount reaches at least 66 2/3% of the original reasonable charge for purchase. This payment, as with all lump-sum reimbursement payments, ends Medicare's responsibility of reim-

bursement for the purchase of equipment. The co-insurance and deductible are the responsibility of the beneficiary. Title passes to the beneficiary when the supplier has received payment for all of the discounted reasonable charges.

If the supplier does not accept assignment for the delayed purchase of new equipment (DLSN), the Medicare reimbursement amount to the beneficiary at the time of the conversion will total 80% of the following: the reasonable purchase price determination at the outset of rental less the discount and the deductible (if applicable). The discount is identical to that described in the preceding paragraph for the supplier accepting assignment. The co-insurance, deductible and dollar difference between the Medicare reimbursement and the actual purchase price is the responsibility of the beneficiary. Title of the equipment passes to the beneficiary when the beneficiary has satisfied his financial obligation to the supplier. Again, Medicare's reimbursement responsibility ends with the lump-sum payment for purchase to the beneficiary.

Payment for the delayed purchase of used equipment (DLSU) may be assigned to the supplier. The Medicare lump-sum reimbursement amount to the supplier at the time of the conversion will be identical to the delayed lump-sum reimbursement for new equipment (DLSN) when the actual purchase price is more than 75% of the original reasonable purchase price determination (made at the outset of rental by the carrier). However, when the actual purchase price at the time of the conversion is at least 25% less than the original reasonable purchase price determination for new equipment, the co-insurance is waived and reimbursement will total 100%, exclusive of any applicable deductible. Title to the equipment

item passes to the beneficiary when the supplier has received payment for the discounted reasonable charge.

If the supplier does not accept assignment for the delayed purchase of used equipment (DLSU), the Medicare lump-sum reimbursement amount to the beneficiary at the time of the conversion is identical to the delayed lump-sum reimbursement for new equipment (DLSN) when the actual purchase price is more than 75% of the original reasonable purchase price determination by the carrier. However, when the actual purchase price at the time of conversion is at least 25% less than the original reasonable purchase price determination for new equipment, the co-insurance is waived. Title to the equipment passes to the beneficiary when the beneficiary has satisfied his financial obligation to the supplier. Again Medicare's reimbursement responsibility ends with the lump-sum payment to the beneficiary for purchase.

Upon transfer of the title under any of the above experimental mechanisms, the supplier no longer has any obligation to provide services to the beneficiary, exclusive of warranties and/or State and commercial codes. Specifically, maintenance and repairs to the purchased item of DME are the responsibility of the beneficiary. Claims may be filed under Part B Medicare for partial payment for maintenance and repairs in accordance with present procedures.

Expected Advantages of Delayed Lump-Sum (DLS) Payment:

- Lower total administrative and billing costs since multiple payments are eliminated by a purchase;

- Potential lower cost to beneficiary since excessive rentals are eliminated;
- Allows the beneficiary time to adjust to an item of DME before making a purchase decision;
- Is acceptable to the suppliers who sell durable medical equipment;
- Potential elimination of a large majority of assignment refusals by suppliers;
- Elimination of the monetary risks imposed by the present method on either the supplier or the beneficiary.

Potential Disadvantages of Delayed Lump-Sum Payment (DLS):

- Cost disadvantage from rental to both the beneficiary and SSA if the beneficiary has a long-term medical need and waits more than one month to convert to a purchase;
- Possible cost disadvantage to beneficiary who purchases when rental would have been cheaper, e.g., beneficiary unexpectedly recovers;
- Possible cost disadvantage to SSA when purchase decision is made when rental would have been cheaper, e.g., beneficiary recovers or dies;
- Beneficiary is now responsible for the maintenance of the equipment;
- Possible overcharge to the beneficiary as individual appraisal of the equipment is not made at the time of delivery;
- Disposal of DME owned by beneficiary or his estate after the period of use has passed.

CHAPTER IV

THE MEDICARE REIMBURSEMENT PROCESS

INTRODUCTION

Reimbursement under Part B of Medicare is made based on a philosophy of reasonable charges to the program's beneficiaries. Regulations and administrative procedures are formulated by the Health Care Financing Administration and are carried out by organizations known as carriers who are contractors to the Federal Government. As contractors, the carriers assume responsibilities including the processing and payment of claims, determination of rates and amounts of payment and consideration of the medical necessity of the equipment or services as a condition for payment. This chapter outlines the statutory and administrative basis that is utilized by the carriers to make payments for DME claims.

THE MEDICARE REASONABLE CHARGE PROCESS

Statutory Provisions

As with other portions of Part B, reimbursement for DME is made on the basis of reasonable charges. The statutory requirements for the determination of reasonable charges are contained in section 1842 (b) (3) of Title XVIII of the Social Security Act (P.L.89-97 as amended).

This section of the Act states:

"No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made With respect to power-operated wheelchairs for which payment is made in accordance with section 1861 (s) (6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgement of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary..." ¹

¹ Social Security Act, Title XVIII, 42 U.S.C. section 1842 (b) (3),
Public Law 89-97, as amended.

The first part of this section deals with the general methodology which is applied to all requests for payment under the Part B program. In its basic form, the methodology has existed since the inception of the program. As indicated, it is the basis of payment for services furnished by physicians, medical groups, independent laboratories, suppliers of ambulance services and suppliers of durable medical equipment and supplies under Part B. The section refers to customary and prevailing charges which are accumulated over an annual period as being the basis for comparison with the submitted or actual amount requested by the claimant.

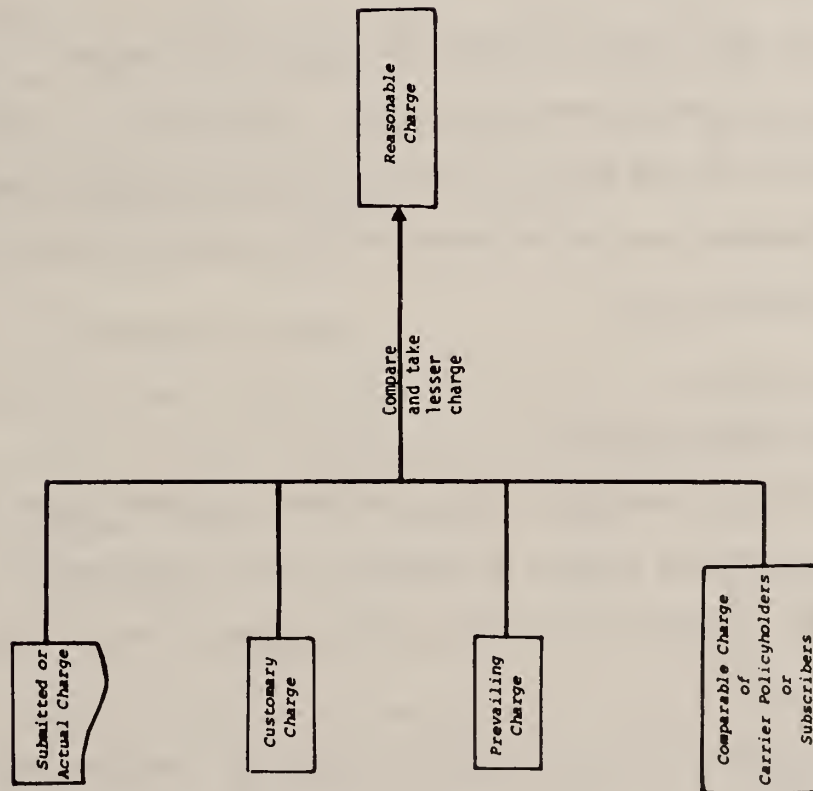
Elsewhere in section 1842 (b) (3) the following is included to provide an additional basis for comparison in the determination of reasonable charges:

" where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier,..." ²

Figure IV-1 illustrates the relationship of the various charges described in the statute in the determination of "reasonable charges".

2 Social Security Act, Title XVIII, 42 U.S.C. section 1842 (b) (3),
Public Law 89-97, as amended.

FIGURE IV-1

GENERAL STATUTORY REASONABLE CHARGE PROCESS

Subsequent to the general description of reasonable charges in Section 1842 are criteria which are applicable specifically to durable medical equipment and other medical supplies. Whereas the previous language refers to customary and prevailing charges without regard to quality or availability, the portion of Section 1842 which relates to the determination of Lowest Charge Levels specifies comparable equipment items of similar quality being widely and consistently available.

Since the data collected during this project and reported in this report do not include experience with the statutory requirement for Lowest Charge Level determinations, the subject is considered only in a qualitative sense. A description of administrative activities relating to these statutory requirements is included in the following section.

Administrative Provisions

As noted, the reasonable charge is the basis of payment under the supplementary medical insurance program for medical and other health services. Durable medical equipment is defined and included in this category of benefits by the statute.

In the administration of the Part B program, the insurance carriers have primary responsibility for determining these charges. The methodology by which they are determined, updated and adjusted, however, is specified broadly in the statute and interpreted by the HCFA Central Office as stated in the Part B Carrier Manual. Further oversight and clarification is provided by the Regional Offices.

Criteria for Determining Reasonable Charges

Two primary general criteria are considered in the determination of reasonable charges by the carriers. They are essentially as specified in section 1842 (b) (3) of Title XVIII cited above, and as follows: (a) the customary charges for similar services generally made by the person furnishing such services; and (b) the prevailing charges in the locality for similar services.

The reasonable charge for a specific item, in terms of any individual request for payment or claim for benefits with which is associated appropriate medical necessity, may not exceed the lowest of the customary charge, the prevailing charge or the submitted charge (actual charge) for the item.

Determination of Reasonable Charges

The typical computerized system which compares the actual or submitted charge with the customary and prevailing charges operates in a somewhat different manner from that depicted in Figure IV-1, however. Figure IV-2 depicts more nearly the process which actually occurs in the determination of the reasonable charge and the allowed charge. The lesser of the customary and prevailing charges is determined and frequently known as the reasonable charge; then the lesser of this reasonable charge and the actual or submitted charge is determined and known as the allowed charge.

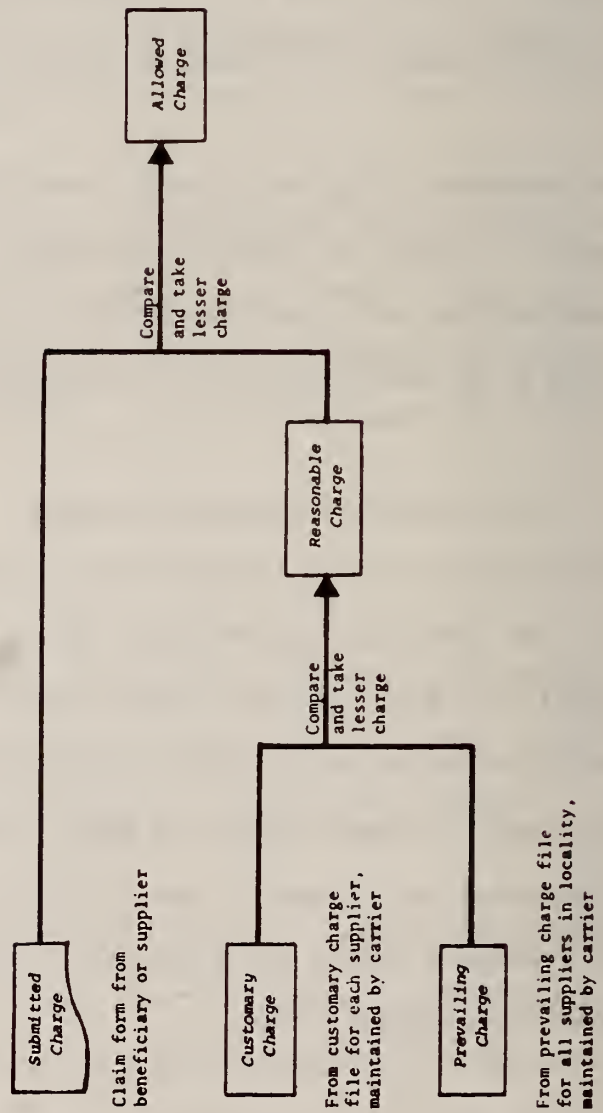
To carry out the reasonable charge provisions of the statute, the Medicare carriers develop and maintain files of the customary charges for DME rendered by the individual suppliers of DME in their service areas and develop prevailing

FIGURE IV-2

TYPICAL SYSTEM DETERMINATION

OF

REASONABLE AND ALLOWED CHARGES



charge screens based on these customary charges. The customary and prevailing charge files used by the carriers are updated as early as possible at the beginning of July, using the available data on charges derived from claims processed during all of the preceding calendar year. Thus, for example, the charge screens used during the period July 1977 - June 1978 would be based on the charges made in calendar year 1976.

Before changes in the customary and prevailing charge files are implemented, the HCFA Regional Office reviews and analyses the changes and to determine whether or not the screens are acceptable. Subsequent to this review, the carriers update the screens and retain the previous year's screens for historical purposes. Claims processing is then continued using the new screens. Additions to and adjustments in the charge screens are undertaken primarily to either add new items or correct errors. Equity adjustments are permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted.

It is noted in the Part B Manual that "other factors" which are necessary and appropriate in individual instances to judge the reasonableness of specific charges may need to be taken into consideration in the determination of reasonable charges. When and if this occurs, however, documentation of the departure from the historical charge data must be provided.

Lowest Charge Level Provisions

The implementation of the Lowest Charge Level provisions of the statute provided, essentially, that reasonable charges for medical services, supplies and equipment (including equipment servicing) that do not vary significantly in quality from one supplier to another may not exceed the lowest charge levels at which such items and services are widely and consistently available in a locality, except to the extent and under the circumstances specified by the Secretary of DHEW. This procedure was recognized as an obvious departure from the traditional reasonable charge methodology for Part B reimbursement in that an additional factor was added as a limit when determining allowed charges.

The lowest charge level limitations initially applied to only two items of DME; a standard wheelchair and a standard hospital bed, as specified below:

1. Standard Wheelchair - one that would generally satisfy the needs of the average-size patient, is fabricated to withstand normal usage and body weight and has brakes and armrests. A wheelchair having any of the following additional features may be considered as standard: eight-inch casters; sling seat (functional for most patients); footplates (including adjustable footplates); and one capable of being easily folded as a complete unit without removing integral parts.
2. Standard Hospital Bed - one that is of a design and construction equal to the standard which is common within the industry, consisting of a

modified gatch spring assembly, mattress and bed ends with casters and manually operated foot end cranks which permit independent adjustment of the elevation of the head and knee sections; is capable of accommodating a standard trapeze bar when attached to the head end; is equipped with IV sockets; is capable of supporting an overhead frame and other accessories that utilize IV holes for mounting purposes; and is equipped to accommodate side rails if required by the patient's condition.

Administrative procedures indicate that the lowest charge level for each listed item and service will be calculated semi-annually, for use in processing claims received on or after July 1 and January 1 of each year. Additionally, for claims processed on or after July 1, determinations will be based on charge data derived from claims processed during the preceding January through March. Similarly, for claims received on or after January 1, reimbursement will be based on charge data derived from claims processed during the preceding July through September.

The lowest charge level was set at the cumulative 25th percentile in the distribution of actual submitted charges for the particular item or service in the locality. In other words, at least one out of four transactions must have been billed for no more than the lowest charge level which has been established by these procedures. The locality designation for the purposes of these lowest charge level provisions is generally assumed to be the entire service area of the carrier.

Now it can be seen that the charge allowed by Medicare is the result of a comparison between: the actual or submitted charge; the customary charge of the individual supplier; the prevailing charge in the locality; the charges applicable for a comparable service and under comparable circumstances to the carrier's private policyholders and subscribers; and, the lowest charge level for those items which are subject to these provisions.

THE MEDICARE PAYMENT PROCESS

Determination of Medical Necessity

Instructions to the carriers from the Federal Government require that a physician's prescription accompany a claim for reimbursement of DME costs. The prescription should include a diagnosis and prognosis of the patient's condition, the reason for prescribing the equipment and an estimate of the number of months the equipment will be needed (the period of medical necessity). Further, when any of this information is missing from existing documentation or correspondence with the beneficiary, supplier, or physician, the carrier may seek further contact for more detailed corroborative information or infer the needed information.

When the physician estimates that a patient needs an item of equipment indefinitely or when he fails to furnish a time estimate, a reevaluation of medical necessity is made six months after the original determination is made, providing reimbursement claims are still being received on behalf of the beneficiary. Technically, a reevaluation of medical necessity is made every six months for the duration of the beneficiary's episode with DME.

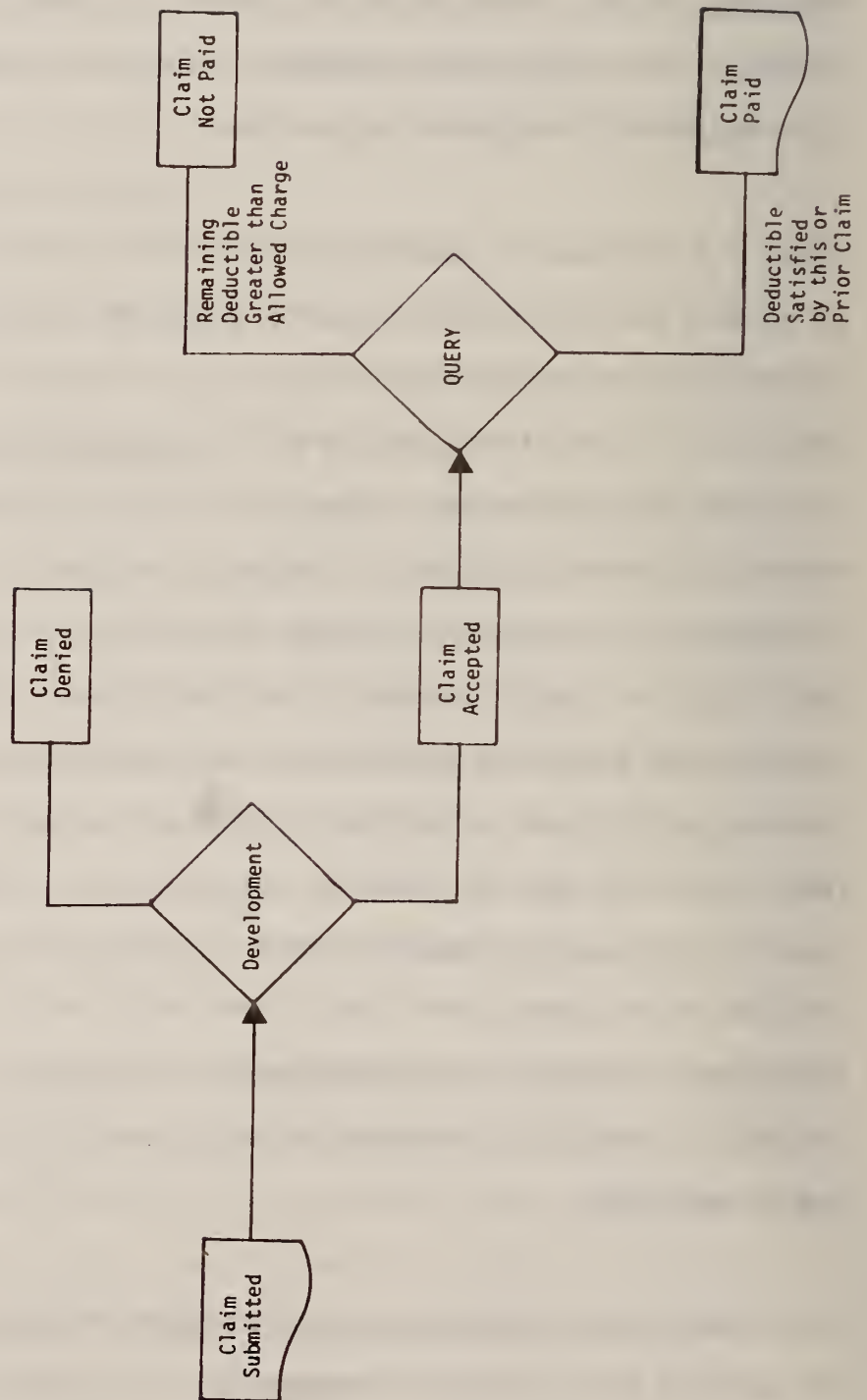
Payment Determination

Subsequent to the receipt of a claim or request for payment, many activities are undertaken by the carrier before any payment is made to a beneficiary or supplier. In this section, denials, reasonable charge reductions and applications of the deductible and co-insurance are considered.

Figure IV-3 illustrates the functional process by which claims that are submitted are verified, and either denied, not paid or paid as the case may be according to the procedures and regulations governing the payment process of Medicare Part B. Simply stated, following the receipt of the claim, the eligibility of the beneficiary and his/her status with respect to payment of the annual deductible is requested from HCFA Central Office files. At this point, the claim may be denied due to ineligibility of the beneficiary. Next, the validity of the claim itself is considered. Specifically, the medical necessity of the benefit being claimed is scrutinized along with the prescription supplied by the physician which presumably contains a diagnosis, prognosis and an estimate of the length of need for the equipment. Again, the claim may be denied at this stage due to non-coverage of the equipment item by the program or inappropriateness of the equipment for the condition of the patient. Other reasons contributing to the denial of the claim include over-utilization of the covered benefit (such as oxygen), filing of duplicate claims by the supplier or beneficiary, or filing of duplicate claims by the supplier and the beneficiary.

Calculation of the reasonable charge or the allowed charge must next be made for the particular item in question. Consideration of the status of the beneficiary's

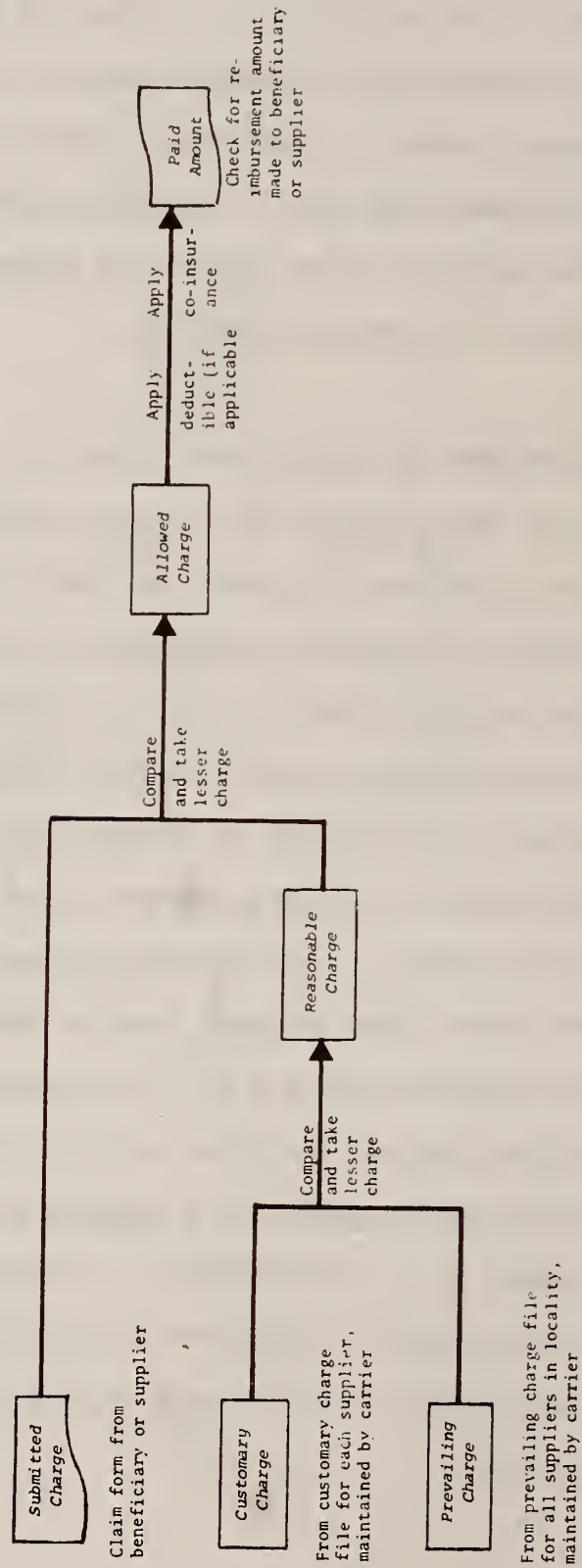
FIGURE IV-3
ADMINISTRATIVE DISPOSITION OF DME CLAIMS



deductible liability is first ascertained. Any amount of the annual deductible which is still due is deducted from the allowed charge calculated for the claim. Then, the co-insurance amount is calculated and deducted from the amount resulting from the allowed charge less any applicable deductible. A check is then issued to either the beneficiary or the supplier if an assignment has been taken by the supplier. Figure IV-4 illustrates this process.

Under additional Medicare Part B procedures which were in effect during the period in which the data presented in this report were developed, if the beneficiary elected to purchase, there were three basic methods of reimbursement for DME. Payment for purchase of inexpensive equipment (items for which the allowed charge was \$50 or less) were made in a lump-sum, subject to the deductible and co-insurance, when it was determined to be less costly or more practical. For expensive items having an allowed charge of more than \$50, payment for the purchase was not made in a lump-sum, but benefits were paid in monthly installments equivalent to the payment which would have been made had the equipment been rented. These payments were, of course, restricted to the established period of medical necessity or until the program's share of the allowed purchase price had been paid, whichever first occurred. Payment in either case could be made directly to the beneficiary or assigned to the supplier of DME. Where payment subject to the deductible and co-insurance was made for the rental of DME, monthly benefits continued for as long as the medical necessity existed. Here again, payment could be made directly to the beneficiary or assigned to the supplier.

FIGURE IV-4
TYPICAL PART B CLAIM PAYMENT DETERMINATION



Assignment Provisions Relating to DME

An assignment is an agreement between a supplier of DME and a beneficiary. Under the terms of the assignment program, which are fixed by law, the beneficiary transfers to the supplier his/her right to benefits based on covered services as specified on the particular claims for being submitted. The supplier in return agrees to accept the reasonable charge as determined by the carrier with jurisdiction over the claim as his full charge for the items of DME being rented or purchased.

In effect, the supplier who accepts assignment is precluded by law from charging the beneficiary more than the deductible (if applicable) and co-insurance based on the reasonable charge determination. If the supplier is dissatisfied with the amount of the reasonable charge, a review may be requested and a hearing may be held, but the assignment agreement is violated if the supplier collects or attempts to collect from the beneficiary any amount which, when added to the determined benefits, is in excess of the reasonable charge. The supplier's bill for the DME is considered paid in full when the reasonable charge has been paid.

The carrier's reasonable charge determination takes into account all of the services rendered by the supplier in connection with the claim. Therefore, a supplier may not charge the beneficiary for "paperwork" involved in filing an assigned claim.

In addition, if the beneficiary has private insurance which supplements Medicare, the supplier who has accepted assignment would be in violation of the assignment

agreement if collections from the private insurer, when added to the Medicare benefits received, exceeded the reasonable charge.

A supplier who accepts assignment for some items of DME is not necessarily precluded from billing the beneficiary for other items. However, if an attempt is made to circumvent the reasonable charge limitation by fragmenting bills, administrative or legal action may be taken by the program. The practice of accepting assignment for some items and not accepting assignment for others for the same beneficiary at the same time and place is also not an acceptable practice. The supplier would be informed that in the future, all items procured on one occasion should be aggregated and either assignment taken for all or for none.

The assignment program has other specific effects on the reimbursement for rental or purchase of DME. An item of DME may have certain convenience or luxury features which make it more expensive than a standard item, i.e., one which will adequately meet the needs of the patient. The reasonable charge for the more expensive item cannot exceed the reasonable charge for the item which is considered to be adequate for the patient's medical needs. Only if a more expensive item or model with specific features is medically necessary for the beneficiary, will the reasonable charge be based on the more expensive model. If the patient purchases or rents an item of DME having more expensive features than his/her condition requires, the supplier accepting assignment on such an item cannot charge or collect any amount in excess of the reasonable charge for the item adequate for the patient's needs. Acceptance of assignment binds the supplier to accept the reasonable charge determined by the carrier as the full

charge for the item. A supplier who wishes to charge and collect the full price for equipment more expensive than medically required by the patient need not accept assignment. In assignment cases, the beneficiary is responsible for paying the supplier the unpaid balance of the reasonable charge if payment stops because his/her condition has changed and the equipment is no longer medically necessary. Similarly, when payments stop because the beneficiary dies, his/her estate is responsible to the supplier for such unpaid balance.

CHAPTER V

FINDINGS

INTRODUCTION

The analysis of both functional- and cost-effectiveness of reimbursement procedures, whether they be experimental or established by revised regulations or new legislation, requires base-line data that will enable critical comparisons. This chapter presents data from historical records of DME claims from the Beneficiary History Files of the carriers who participated in the project. The time span of the data is the calendar years 1976 and 1977 with the exception of the Equitable Life Assurance Society Tennessee site, for which data were available only from 1976. In addition, data from Washington Physicians Service after October 31, 1977 are not included in the summary remarks as the reimbursement experiment became operational after that date. Experience with DME at Washington Physicians Service subsequent to that date is included separately.

The profile of characteristics of DME claims obtained from the data from these several recent years will provide for comparative analyses of data reported on the transactions occurring under the revised procedures related to the implementation of Section 16 of P.L. 95-142 or other new procedures. The results will also provide for evaluations of the viability of the reimbursement procedures as well as their effectiveness and suitability with respect to the intent of the law governing HCFA programs.

CHARACTERISTICS OF THE PROJECT SAMPLE

According to data compiled by the Medicare Bureau, there were 24,555,578 Medicare Part B beneficiaries as of July 1, 1976. Table V - 1 presents data to indicate the distribution of these beneficiaries among the ten DHEW Regions and the Railroad Retirement Board.

Following solicitation efforts, in which the carriers listed in Table V - 2 were contacted and/or visited, the carriers who agreed to participate in the project were: The Equitable Life Assurance Society of the United States; Group Health Incorporated; Occidental Life of California; The Travelers Insurance Company; and, The Washington Physicians Service.

Table V - 3 indicates the SMI enrollment of these participating carriers by service area, carrier and percent of total SMI enrollment. Table V - 4 shows these data except by HEW Region.

Table V - 5 presents data indicating the distribution of enrollees by DHEW Region both in total and for the participating carriers. Further, it shows the percentage of enrollees by the participating carriers within each Region.

From the data presented in these tables, several characteristics of the project sample become clear.

1. Of the 24,555,578 persons enrolled in Part B of Medicare, this study has developed data based on a group numbering 3,724,384. This constitutes a 15.2 per cent sample of the universe of Part B beneficiaries.
2. These beneficiaries are not spread uniformly throughout the DHEW Regions, but rather they represent anywhere from zero to 62.8 per cent of the beneficiary population in any one region. (It should also be noted that neither are Medicare beneficiaries in general spread evenly throughout the regions.
3. A mix of carriers by size of enrollment has been included in the project sample.
4. A geographic dispersion of the carriers to be included in the study was required and after attempts were made to satisfy this requirement, a reasonable geographic coverage of the nation was included in the project sample.

TABLE V - 1:

SMI Enrollment and Percent SMI Enrollment by HEW Region, As of July 1, 1976

REGION	<u>Persons Enrolled</u>	<u>Percent of Total Persons Enrolled</u>
I	1,450,934	5.9
II	3,088,132	12.6
III	2,569,183	10.5
IV	4,205,461	17.1
V	4,720,073	19.2
VI	2,320,238	9.4
VII	1,459,668	5.9
VIII	578,449	2.4
IX	2,565,056	10.4
X	745,072	3.0
RAILROAD RETIREMENT BOARD	853,312	3.5
TOTAL ENROLLMENT FOR ALL SMI CARRIERS	24,555,578	

TABLE V - 2:

Carriers Contacted or Visited and Invited to Participate in the Experiment

<u>CARRIER</u>	<u>NO. OF STATES*</u>	<u>STATES</u>
Aetna Life Insurance Company	6	OR, AK, OK, HI, AZ, NV
Blue Shield of Florida	1	FL
California Physicians Service	1	CA
Colorado Medical Service, Inc.	1	CO
The Equitable Life Assurance Society of the U.S.	4	TN, NM, WY, ID
Group Health Incorporated	2	NY, FL
Group Medical and Surgical Service	1	TX
Kansas Physicians Service	1	KS
Maryland Medical Service	1	MD
Medical Service of D.C.	3	D.C., MD, VA
Medical Service Association of Pennsylvania	1	PA
Metropolitan Life Insurance Co.	2	NY, KY
Michigan Medical Service	1	MI
Nationwide Mutual Insurance Co.	2	OH, WV
Occidental Life of California	1	CA
Rhode Island Medical Society	1	RI
The Travelers Insurance Co.	3	VA, MS, MN
United Medical Service, Inc.	1	NY
Washington Physicians Service	1	WA

* Or parts of states served by the carrier

TABLE V - 3:

SMI Enrollment by Participating Carrier and Service Area, As of July 1, 1976

<u>Carrier Service Area</u>	<u>Persons Enrolled By Service Area</u>	<u>Persons Enrolled By Carrier</u>	<u>Enrollment By Participating Carrier as a Percent of Total SMI Enrollment</u>
EQUITABLE LIFE		694,470	2.83
Tennessee	481,467		1.96
New Mexico	97,924		0.40
Wyoming	32,231		0.13
Idaho	82,848		0.34
GROUP HEALTH INCORPORATED		479,968	1.96
New York	252,021		1.03
Florida	227,947		0.93
OCCIDENTAL LIFE		1,282,195	5.22
California	1,282,195		5.22
THE TRAVELERS INSURANCE COMPANY		882,539	3.59
Virginia	407,278		1.66
Mississippi	278,454		1.13
Minnesota	196,807		0.80
WASHINGTON PHYSICIANS SERVICE		385,212	1.57
Washington	385,212		1.57
TOTAL ENROLLMENT FOR ALL PARTICIPATING CARRIERS		3,724,384	15.17
TOTAL ENROLLMENT FOR ALL SMI CARRIERS		24,555,578	100.00

TABLE V - 4:

SMI Enrollment by DHEW Region and Participating Carrier(As of July 1, 1976)

<u>DHEW Region</u>	<u>Service Area And Carrier</u>	<u>Persons Enrolled By Participating Carriers</u>	<u>Persons Enrolled By Carrier Service Area</u>
I	Region Total	NONE	
II	Region Total	252,021	
	NY - Group Health Incorporated		252,021
III	Region Total	407,278	
	VA - Travelers Insurance Company		407,278
IV	Region Total	987,868	
	FL - Group Health Incorporated		227,947
	MS - Travelers Insurance Company		278,454
	TN - Equitable Life Assurance Society		481,467
V	Region Total	196,807	
	MN - Travelers Insurance Company		196,807
VI	Region Total	97,924	
	NM - Equitable Life Assurance Society		97,924
VII	Region Total	NONE	
VIII	Region Total	32,231	
	WY - Equitable Life Assurance Society		32,231
IX	Region Total	1,282,195	
	CA - Occidental Life of California		1,282,195
X	Region Total	486,060	
	ID - Equitable Life Assurance Society		82,848
	WA - Washington Physicians Service		385,212
TOTAL ENROLLMENT FOR ALL PARTICIPATING CARRIERS		3,724,384	

TABLE V - 5:

SMI Enrollment by: Region, Participating Carriers, Within Region and
Participating Carriers as a Percentage of Regional Enrollment, as of July 1, 1976

	<u>Total Persons Enrolled</u>	<u>Persons Enrolled By Participating Carriers</u>	<u>Enrollment By Participating Carrier as a Percent of Regional Enrollment</u>
REGION			
I	1,450,934	-0-	0.0
II	3,088,132	252,021	8.2
III	2,569,183	407,278	15.9
IV	4,205,461	987,868	23.5
V	4,720,073	196,807	4.2
VI	2,320,238	97,924	4.2
VII	1,459,668	-0-	0.0
VIII	578,449	32,231	5.6
XI	2,565,056	1,282,195	50.0
X	745,072	468,060	62.8
RAILROAD RETIREMENT BOARD	853,312		0.0
TOTAL ENROLLMENT	24,555,578	3,724,384	15.2

DATA COLLECTION AND EXTRACTION

To satisfy the need for data concerning the dimensions and magnitude of the DME portion of the Medicare Part B program, a major project task was included which provided for the collection, tabulation and presentation of historical DME reimbursement data. From the carriers who agreed to participate in the project were solicited computer tapes containing records of DME claims processed during 1976 - 1977. These requests often resulted in the receipt of copies of each carrier's Beneficiary History File which contains records of the entire experience of the Medicare Part B beneficiaries for some specific period. That is, they contain records of charges relating to physicians, DME, ambulance usage, laboratory fees and all other services covered by Part B. From this extremely large database of roughly 20 million records, approximately 1.3 million were extracted as relating to DME.

The first step in the extraction process necessitated identifying the appropriate DME line items or claims or portions thereof. Each carrier maintains a list of procedure codes which classify DME by type of item. It was found that these classification schemes vary widely from carrier to carrier both in the depth with which they classify generic categories of DME and in the volume of items classified. Therefore, the responsibility for coordinating these classification schemes with associated procedure codes became a subtask of the project effort.

The classification methodology which was developed contains nine broad categories of DME each containing the appropriate equipment items. These broad categories are:

- 1) Hospital beds and accessories
- 2) Commode chairs, bedpans, urinals, and toilet accessories
- 3) Canes, crutches, and accessories
- 4) Traction equipment and accessories
- 5) Walkers and walking aids
- 6) Wheelchairs and accessories
- 7) Oxygen and oxygen therapy equipment
- 8) Pads and cushions
- 9) Miscellaneous DME including repairs and maintenance.

APPENDIX N includes information from the classification schemes or procedure code systems of the carriers which has been re-classified by these nine categories.

Preliminary tabulations of the data were made to determine various characteristics relating to each line item of each claim involving DME. Certain idiosyncracies of the various data processing systems used by the carriers became apparent at this point. First, since clerical and data processing systems used by the carriers evolve over time in response to both new items of DME and administrative regulations, the state of the procedure code systems is not fixed. In fact, several of the carriers revamped their coding structure as a result of recommendations made during the course of the project. In some cases documentation of changes to these systems lags somewhat behind the changes

themselves. In other cases, procedure codes were identified which appear to be within the realm of DME but which were not readily identifiable by the carriers. These may have been codes which had been recently added or errors of a data input variety.

Another source of confusion relating to the data which were extracted was the fact that the Beneficiary History Files covered different periods of time. Although these files are updated and purged by the carriers at approximately the same time each year, often several months elapse during which this process takes place for all carriers. In addition, it is not known how and to what extent this purging operation affects the claims residing in the Beneficiary History File. Therefore, preliminary tabulations represented documentation of the data which were currently in the Beneficiary History Files. Subsequent analysis of the database showed that the data in the earlier years (e.g., 1973, 1974, 1975) were often incomplete. Thus, although some data remained on file with the Medicare carriers, only 1976 and 1977 data were judged to be complete and comparable for tabulation and analysis.

To complicate this matter further, Medicare law and regulations allow for the submission of claims up to 27 months after services were rendered. Therefore, some of the claims in the data base, although processed by the carrier during the stated period, 1976 - 1977, relate to experiences with DME that occurred over the two previous years. For purposes of this study, information has been tabulated relating to the time period in which the claims were processed rather than by service dates.

PRESENTATION OF THE DATA

DME Use by Part B Beneficiaries

Subsequent to the extraction of DME claims, various aspects of the information contained in the claims records were investigated. Of primary interest was the number of DME users in the Medicare Part B beneficiary population. The intensity of DME use by beneficiaries may be measured only by proxy, i.e. by counting the number of beneficiaries who had, in the past, submitted claims for reimbursement. Table V - 6 tabulates these DME users by both the participating carriers and their various service areas. In total, the experience of 403,818 beneficiaries was analyzed with respect to their use of DME.

Although it has been assumed from the outset of the project that regional differences of a variety of sorts would be encountered, no attempt during this project was undertaken to determine these differences in a systematic manner.

Several factors which are largely unknown could contribute to the differences in ratios of DME users to program enrollees as seen in the following tables. A prominent factor could be effects of the State-operated Medicaid programs and their policies concerning reimbursement and coverage of DME. Certainly medical practice differences concerning hospitalization or other institutionalization rather than home care could be another causal factor. A third might be general socioeconomic characteristics or folkways of the beneficiaries as they relate both to institutionalization versus home care and the use of equipment items such as those covered in the Part B program.

Table V - 7 tabulates these same data as well as the SMI enrollment figures for the same carriers and geographic service areas. Table V - 8 presents data derived from the previous table relating to the percentages of DME users to the total participating carrier enrollment (3,724,384 as of July 1, 1976). It can be seen that the DME users are a small percentage (10.86%) of the total enrollment of the five carriers. Stated another way, Table V - 8 indicates that almost 11 percent of the total enrollment of the participating carriers had some experience with DME in a reimbursement sense.

Table V - 9, on the other hand, presents data which indicate the percentage of DME users as it relates to the enrollment of each service area and of each carrier, rather than the combined total carrier enrollment as before. The table also shows the small percentage of DME users except in the Occidental Life of California service area in which almost 22% of Part B enrollees filed at least one claim for DME in 1976 - 1977. Notable also are the relatively large percentages of DME users in Idaho (14%) and Florida (10%) as reflected by the Equitable Life Assurance Society entire state service area and the Group Health Incorporated service area in southern Florida.

Table V - 10 displays some of the same data except by DHEW region. This table serves as a place for compilation rather than comparison. For comparative purposes, Table V - 11 shows the percentages of DME users out of the total enrollment of the participating carriers as they reflect regional differences. Relatively large differences between regional percentages of DME users are seen, again particularly in the case of the region in which Occidental Life of California

falls. Table V - 12 shows these same data except that the DME users within each carrier and carrier service area are compared to the enrolled beneficiaries within the same area rather than to the entire sample used for the project. With the exception of Region IX, (with a percentage of DME users of 21.9%) the proportion of DME users is relatively stable, with a low of 2.8% to a high of 7.5%. Again, the overall proportion of DME users to enrolled beneficiaries was found to be 10.86%.

TABLE V - 6:

DME Users by Participating Carrier and Service Area

<u>Carrier and Service Area</u>	<u>DME Users in Service Area</u>	<u>DME Users by Carrier</u>
EQUITABLE LIFE ASSURANCE SOCIETY		32,864
Idaho	11,702	
New Mexico	7,328	
Tennessee	12,943	
Wyoming	891	
GROUP HEALTH INCORPORATED		31,234
Florida	23,229	
New York	8,005	
OCCIDENTAL LIFE OF CALIFORNIA		281,217
TRAVELERS INSURANCE COMPANY		46,313
Minnesota	8,302	
Mississippi	18,817	
Virginia	19,194	
WASHINGTON PHYSICIANS SERVICE		12,190
TOTAL		403,818

TABLE V - 7:

SMI Enrollees (As of July 1, 1976) and DME Users
by Participating Carrier and Service Area

<u>Carrier Service Area</u>	<u>DME Users</u>	<u>SMI Enrollees</u>
EQUITABLE LIFE ASSURANCE SOCIETY	32,864	694,470
Idaho	11,702	82,848
New Mexico	7,328	97,924
Tennessee	12,943	481,467
Wyoming	891	32,231
GROUP HEALTH INCORPORATED	31,234	479,968
Florida	23,229	227,947
New York	8,005	252,021
OCCIDENTAL LIFE OF CALIFORNIA	281,217	1,282,195
TRAVELERS INSURANCE COMPANY	46,313	822,539
Minnesota	8,302	196,807
Mississippi	18,817	278,454
Virginia	19,194	407,278
WASHINGTON PHYSICIANS SERVICE	12,190	385,212
TOTAL	403,818	3,724,384

TABLE V - 8:

DME Users as a Percentage
of Total Participating Carrier Enrollees
by Carrier and Service Area

<u>Carrier and Service Area</u>	<u>Percentage of DME Users in Service Area</u>	<u>Percentage of DME Users By Carrier</u>
EQUITABLE LIFE ASSURANCE SOCIETY		0.89
Idaho	0.32	
New Mexico	0.20	
Tennessee	0.35	
Wyoming	0.02	
GROUP HEALTH INCORPORATED		0.84
Florida	0.62	
New York	0.22	
OCCIDENTAL LIFE OF CALIFORNIA		7.55
TRAVELERS INSURANCE COMPANY		1.25
Minnesota	0.22	
Mississippi	0.51	
Virginia	0.52	
WASHINGTON PHYSICIANS SERVICE		0.33
TOTAL FOR ALL AREAS		10.86

TABLE V - 9:

DME Users as a Percentage
of Carrier and Service Area Enrollment
by Carrier and Service Area

<u>Carrier and Service Area</u>	<u>Percentage of DME Users in Service Area</u>	<u>Percentage of DME Users By Carrier</u>
EQUITABLE LIFE ASSURANCE SOCIETY		4.73
Idaho	14.13	
New Mexico	7.97	
Tennessee	2.69	
Wyoming	2.77	
GROUP HEALTH INCORPORATED		6.51
Florida	10.19	
New York	3.18	
OCCIDENTAL LIFE OF CALIFORNIA		21.93
TRAVELERS INSURANCE COMPANY		5.63
Minnesota	4.22	
Mississippi	6.76	
Virginia	4.71	
WASHINGTON PHYSICIANS SERVICE		3.17

TABLE V - 10:

DME Users by DHEW Region, Participating Carrier and Service Area

<u>DHEW Region</u>	<u>Service Area And Carrier</u>	<u>DME Users in Service Area</u>	<u>DME Users by Carrier</u>
I	Region Total		NONE
II	Region Total		8,005
	NY - Group Health Incorporated	8,005	
III	Region Total		19,194
	VA - Travelers Insurance Company	19,194	
IV	Region Total		54,989
	FL - Group Health Incorporated	23,229	
	MS - Travelers Insurance Company	18,817	
	TN - Equitable Life Assurance Society	12,943	
V	Region Total		8,302
	MN - Travelers Insurance Company	8,302	
VI	Region Total		7,328
	NM - Equitable Life Assurance Society	7,328	
VII	Region Total		NONE
VIII	Region Total		891
	WY - Equitable Life Assurance Society	891	
IX	Region Total		281,217
	CA - Occidental Life of California	281,217	
X	Region Total		23,892
	ID - Equitable Life Assurance Society	11,702	
	WA - Washington Physicians Service	12,190	
TOTAL DME USERS			403,818

TABLE V - 11:

DME Users as a Percentage
of Total Participating Carrier Enrollment
by DHEW Region and Carrier Service Area

<u>DHEW Region</u>	<u>Service Area And Carrier</u>	<u>Percentage of DME Users in Service Area</u>	<u>Percentage of DME Users by Carrier</u>
I	Region Total		NONE
II	Region Total		0.22
	NY - Group Health Incorporated	0.22	
III	Region Total		0.52
	VA - Travelers Insurance Company	0.52	
IV	Region Total		1.48
	FL - Group Health Incorporated	0.62	
	MS - Travelers Insurance Company	0.51	
	TN - Equitable Life Assurance Society	0.35	
V	Region Total		0.22
	MN - Travelers Insurance Company	0.22	
VI	Region Total		0.20
	NM - Equitable Life Assurance Society	0.20	
VII	Region Total		NONE
VIII	Region Total		0.02
	WY - Equitable Life Assurance Society	0.02	
IX	Region Total		7.55
	CA - Occidental Life of California	7.55	
X	Region Total		0.65
	ID - Equitable Life Assurance Society	0.32	
	WA - Washington Physicians Service	0.23	
TOTAL FOR ALL REGIONS			10.86

TABLE V - 12:

DME Users as a Percentageof Carrier and Service Area Enrollmentby DHEW Region and Carrier Service Area

<u>DHEW Region</u>	<u>Service Area And Carrier</u>	<u>Percentage of DME Users in Service Area</u>	<u>Percentage of DME Users by Carrier</u>
I	Region Total		NONE
II	Region Total		3.18
	NY - Group Health Incorporated	3.18	
III	Region Total		4.71
	VA - Travelers Insurance Company	4.71	
IV	Region Total		5.57
	FL - Group Health Incorporated	10.19	
	MS - Travelers Insurance Company	6.76	
	TN - Equitable Life Assurance Society	2.69	
V	Region Total		4.22
	MN - Travelers Insurance Company	4.22	
VI	Region Total		7.48
	NM - Equitable Life Assurance Society	7.48	
VII	Region Total		NONE
VIII	Region Total		2.77
	WY - Equitable Life Assurance Society	2.77	
IX	Region Total		21.93
	CA - Occidental Life of California	21.93	
X	Region Total		4.92
	ID - Equitable Life Assurance Society	14.13	
	WA - Washington Physicians Service	3.16	

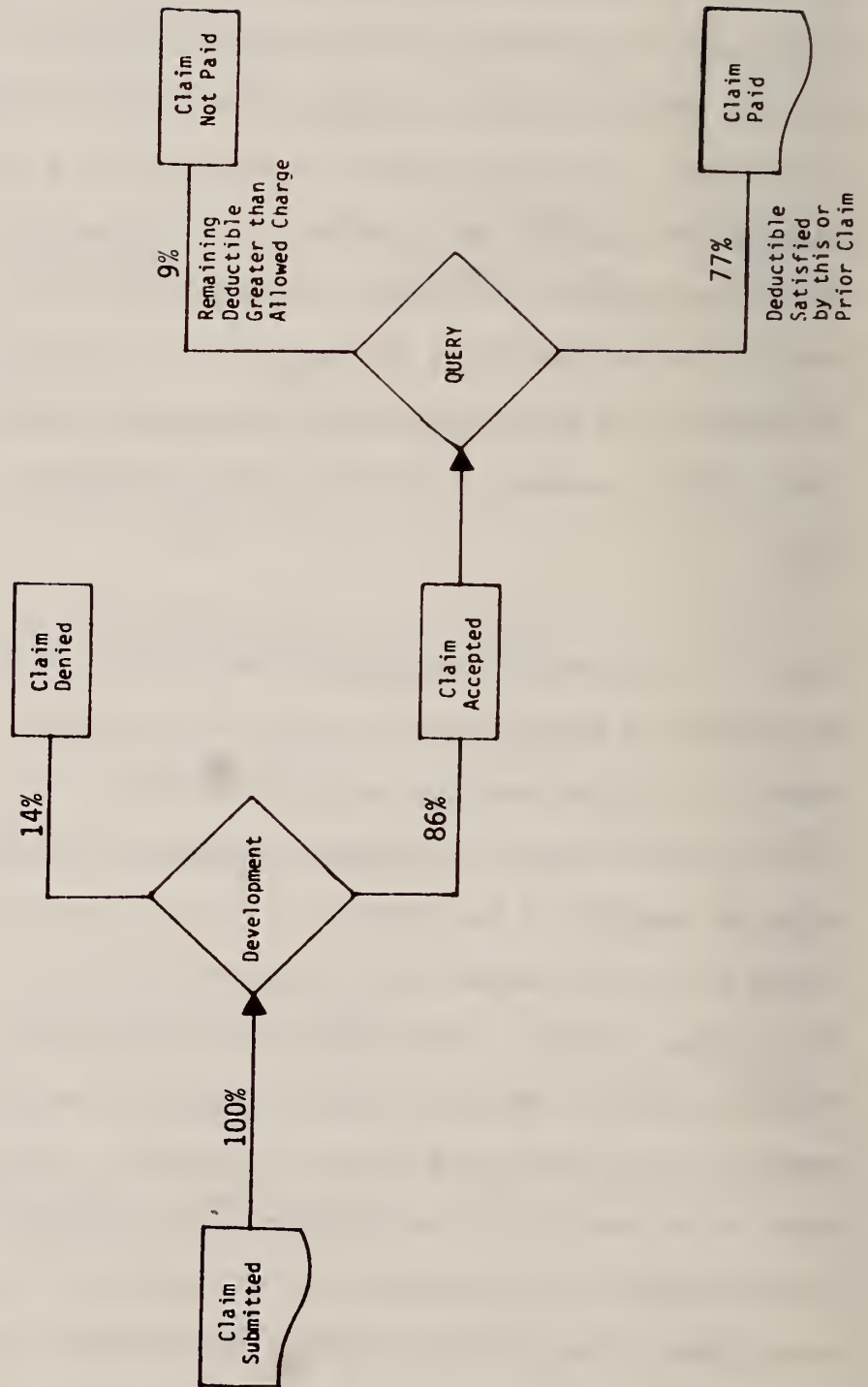
Characteristics of the Claims Flow

The Medicare claim adjudication and payment process is described in Chapter IV of this report in some detail, however, quantitative aspects of the flow of claims within the system and statistics relating to the makeup of claims are considered in this section. As noted, subsequent to the receipt of a claim or request for payment, many activities are undertaken by the carrier before any payment is made to the beneficiary or supplier. In this section, denials, reasonable charge reductions and applications of the deductible and co-insurance are considered. The analysis in this section is based on data from 403,818 beneficiaries who filed 872,275 claims containing 1,277,673 line items requesting reimbursement for DME.

Figure V - 1 illustrates the functional process by which claims that are submitted are verified and either denied, not paid or paid as described in the previous chapter. In addition, the figure notes percentages of line items resulting from action taken with respect to the processing of the claim. Following receipt of the claim, the eligibility of the beneficiary and his/her status with respect to the liability for the annual deductible are requested from HCFA Central Office files. At this point, the claim may be denied due to ineligibility of the beneficiary. Next, the validity of the claim itself is considered. Specifically, the medical necessity of the benefit being claimed is scrutinized. Again, the claim may be denied at this stage due to non-coverage of the equipment by the program or inappropriateness of the equipment for the condition of the patient. Other reasons noted in Chapter IV also contribute to the denial of claims.

FIGURE V-1

ADMINISTRATIVE DISPOSITION OF DME CLAIMS



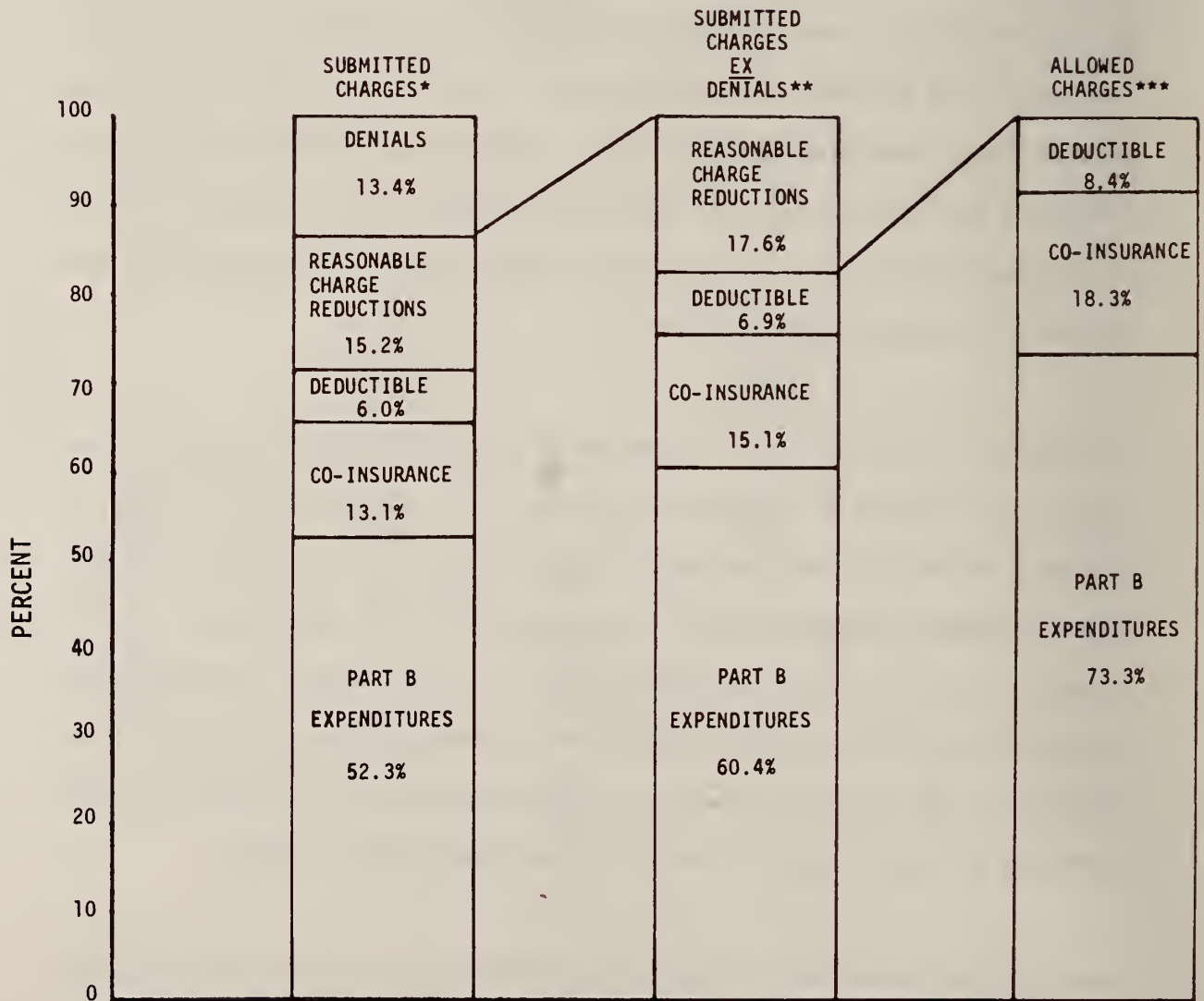
Data collected from the carriers participating in the project which relate to these general issues are tabulated and found in APPENDIX A. These data indicate that some 14 percent of the line items of claims for DME are denied by the carriers. Of the remaining 86 percent of the line items which are not denied, a determination of payment must be undertaken. Calculation of the reasonable or allowed charge must be made for the particular item in question and for the particular supplier if an assignment has been taken. Consideration of the status of the beneficiary's deductible liability must also be ascertained at this point. Any amount of the annual deductible which is still due is deducted from the allowed charge calculated for the claim. Finally, the co-insurance amount is calculated and deducted from the amount resulting from the allowed charge less any applicable deductible. A check is then issued to either the beneficiary of the supplier if an assignment has been taken.

As Figure V - 1 indicates, only 77 percent of the submitted line items of claims result in the issuance of a check and payment by the Medicare Part B program. Fourteen percent of the line items are denied prior to determination of the allowed charges, presumably due to ineligibility of the beneficiary or non-coverage of the item for which reimbursement is being sought. Nine percent of the line items which continue through the processing system do not result in payments by the program because the deductible has not been satisfied e.g., the remaining deductible is greater than the allowed charge for the claim.

Several tables follow which indicate the distribution of line items and claims among the carriers participating in the project. In addition, ratios of line items

FIGURE V-2

**CHARGE AND EXPENDITURE RELATIONSHIPS RELATING
TO DME IN MEDICARE PART B**



- * Column Percents of Submitted Charges
 ** Column Percents of Submitted Charges less Denials
 *** Column Percents of Allowed Charges

per claim, line items per beneficiary and claims per beneficiary are noted. Table V - 13 through V - 15 contain these data, respectively. Figure V - 2 illustrates the effects of denials, reasonable charge reductions, deductible payments and co-insurance payments on the actual or submitted charges of claims. The net result of these four steps in the adjudication of a Part B claim is the payment of only 52.3 percent of the submitted charges. This result, however, must be viewed with some caution because it is based on the totality of submitted charges, including charges on claims which are subsequently denied. The figure also includes several alternative views of this process. Perhaps the middle column best illustrates the effects of these aspects of the program in the payment of claims for covered services. In this case, it can be seen that reimbursement for covered services by the Part B program accounts for approximately 60 percent of the charges for those covered services and items of equipment.

APPENDIX A presents data from the carriers which indicate in detail the status of line items of claims with respect to their submittal, denial, non-payment or payment. Both the numbers of line items in each category and the appropriate charges for those line items are presented. The tabulations are presented in an overall summary table first, although this table does not include information on submitted and denied line items as comparable data were not available from all the participating carriers. Other tabulations are presented for each carrier and for each service area of the carrier separately.

It should be noted that data contained in the previous figures in this section were derived from only four carriers covering all or parts of ten states.

TABLE V - 13:

DME: Line Items, Claims, and Line Items per Claim
by Participating Carrier and Service Area

<u>Carrier and Service Area</u>	<u>Line Items</u>	<u>Claims</u>	<u>Line Items Per Claim</u>
EQUITABLE LIFE ASSURANCE SOCIETY	217,399	116,676	1.9
Idaho	54,394	37,192	1.5
New Mexico	61,066	28,939	2.1
Tennessee	97,359	47,965	2.0
Wyoming	4,580	2,580	1.8
GROUP HEALTH INCORPORATED	291,163	145,116	2.0
Florida	234,782	111,27	2.1
New York	56,381	33,899	1.7
OCCIDENTAL LIFE OF CALIFORNIA	432,293	394,872	1.1
TRAVELERS INSURANCE COMPANY	258,477	172,477	1.5
Minnesota	52,469	36,874	1.4
Mississippi	104,909	74,000	1.4
Virginia	101,099	61,844	1.6
WASHINGTON PHYSICIANS SERVICE	78,341	42,893	1.8
TOTAL	1,277,673	872,275	
OVERALL AVERAGE			1.5

TABLE V - 14:

DME: Line Items, Beneficiaries, and Line Items per Beneficiaryby Participating Carrier and Service Area

<u>Carrier and Service Area</u>	<u>Line Items</u>	<u>Bene- ficiaries</u>	<u>Line Items Per Beneficiary</u>
EQUITABLE LIFE ASSURANCE SOCIETY	217,399	32,864	6.6
Idaho	54,394	11,702	4.6
New Mexico	61,066	7,328	8.3
Tennessee	97,359	12,943	7.5
Wyoming	4,580	891	5.1
GROUP HEALTH INCORPORATED	291,163	31,234	9.3
Florida	234,782	23,229	10.1
New York	56,381	8,005	7.0
OCCIDENTAL LIFE OF CALIFORNIA	432,293	281,217	1.5
TRAVELERS INSURANCE COMPANY	258,477	46,313	5.6
Minnesota	52,469	8,302	6.3
Mississippi	104,909	18,817	5.6
Virginia	101,099	19,194	3.2
WASHINGTON PHYSICIANS SERVICE	78,341	12,190	6.4
TOTAL	1,277,673	403,818	
OVERALL AVERAGE			3.2

TABLE V - 15:

DME: Claims, Beneficiaries, and Claims per Beneficiary
by Participating Carrier and Service Area

<u>Carrier and Service Area</u>	<u>Claims</u>	<u>Bene- ficiaries</u>	<u>Claims Per Beneficiary</u>
EQUITABLE LIFE ASSURANCE SOCIETY	116,676	32,864	3.6
Idaho	37,192	11,702	3.2
New Mexico	28,939	7,328	3.9
Tennessee	47,965	12,943	3.7
Wyoming	2,580	891	2.9
GROUP HEALTH INCORPORATED	145,116	31,234	4.7
Florida	111,217	23,229	4.8
New York	33,899	8,005	4.2
OCCIDENTAL LIFE OF CALIFORNIA	394,872	281,217	1.4
TRAVELERS INSURANCE COMPANY	172,718	46,313	3.7
Minnesota	36,874	8,302	4.4
Mississippi	74,000	18,817	3.9
Virginia	61,844	19,194	5.3
WASHINGTON PHYSICIANS SERVICE	42,893	12,190	3.5
TOTAL	872,275	403,818	
OVERALL AVERAGE			2.2

Reimbursement by Monetary Class Intervals

At the outset of the project it was thought that information relating to the volume of claims for DME which fall into class intervals by monetary values might be of some value in understanding the typical situation in which a beneficiary exists with regard to both reimbursement by Medicare and liability for deductible and co-insurance amounts. In addition, this type of information is useful when viewed in the context of policy changes in the deductible amount. Further, certain inferences with regard to the administrative effort involved in processing DME claims may be made.

Table V - 16 tabulates the frequency of line items of claims and dollar amounts which were paid for those line items arranged into \$50 class intervals. These data reflect the experience of all the participating carriers. Detailed tabulations relating to each carrier may be found in APPENDIX C.

Figure V - 3 illustrates the frequency of these overall data. Considering the rental data first, it can be seen that some 99 percent of the line items and 92 percent of the associated reimbursements were \$100 or less. Conversely, only 1 percent of the line items of claims for rental were ever reimbursed more than \$100.

The situation with purchases is somewhat different, however. Here, 97 percent of the line items and only 73 percent of the associated reimbursements were found

TABLE V - 16:

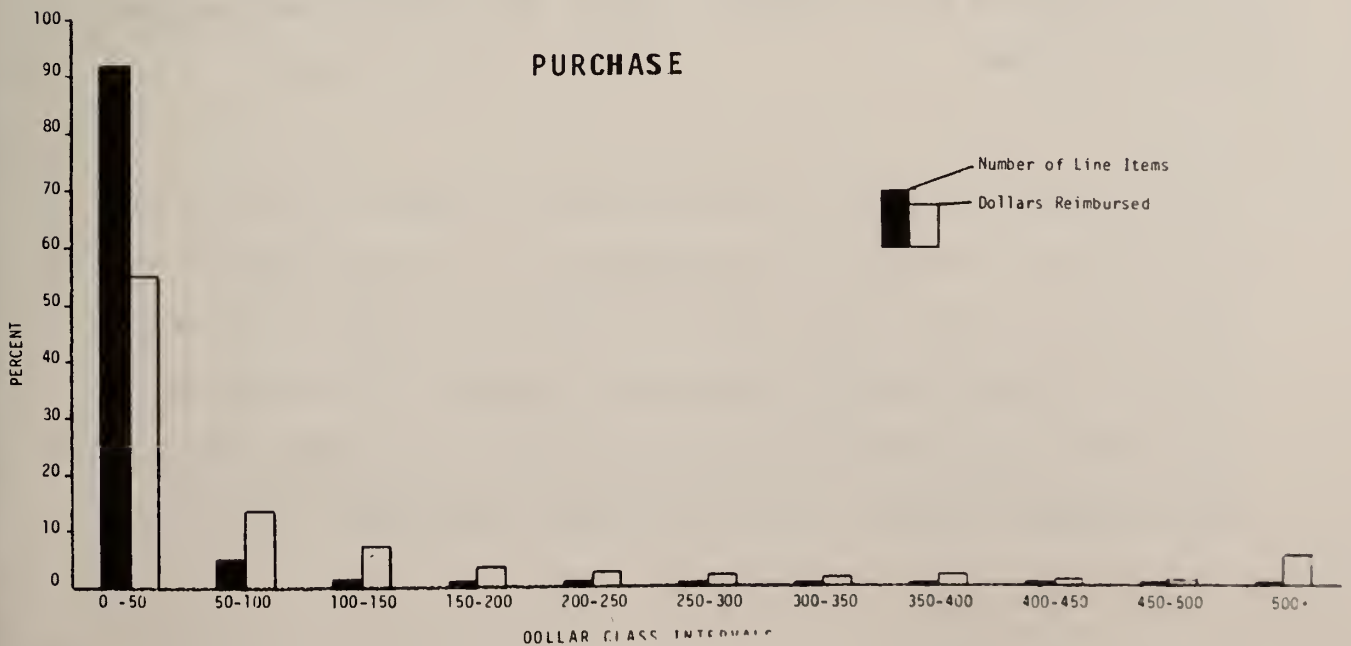
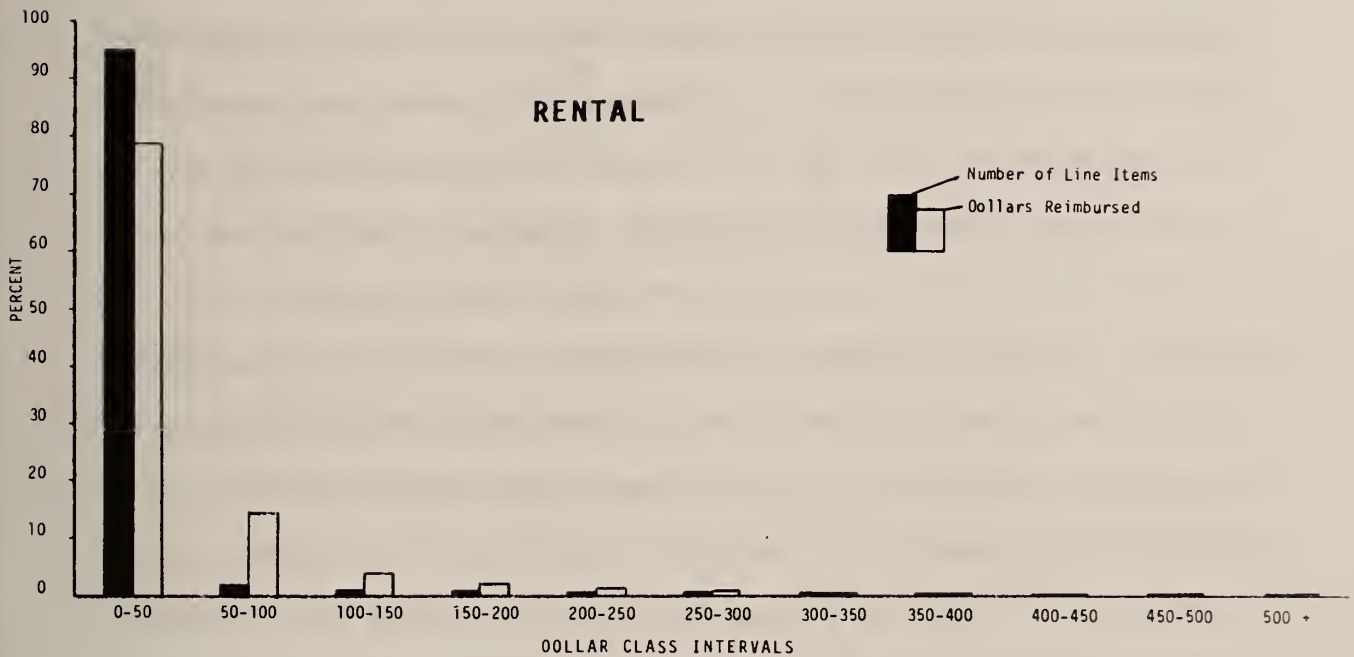
Percent of DME Rental and Purchase Reimbursement by Class Intervals of \$ 50

All Participating Carriers (1976 - 1977)*

LINE ITEM REIMBURSEMENT INTERVAL	RENTAL		PURCHASE	
	PERCENT OF LINE ITEMS	PERCENT OF DOLLARS PAID	PERCENT OF LINE ITEMS	PERCENT OF DOLLARS PAID
\$ 0.01 - \$ 50.00	94.80	78.34	91.81	58.00
\$ 50.01 - \$100.00	4.27	13.97	5.17	14.79
\$100.01 - \$150.00	0.57	3.70	1.51	7.80
\$150.01 - \$200.00	0.22	2.02	0.61	4.48
\$200.01 - \$250.00	0.07	0.87	0.29	2.73
\$250.01 - \$300.00	0.03	0.43	0.18	2.08
\$300.01 - \$350.00	0.01	0.19	0.11	1.52
\$350.01 - \$400.00	0.01	0.17	0.07	1.09
\$400.01 - \$450.00	0.01	0.06	0.05	0.90
\$450.01 - \$500.00	0.00	0.03	0.04	0.82
\$500.01 and above	0.01	0.22	0.16	5.79

* 1977 data not available from Equitable Life Assurance Society - Tennessee site

FIGURE V-3
DISTRIBUTION FREQUENCY OF REIMBURSEMENT
FOR DME



on claims for \$100 or less. Thus, some 3 percent of the line items found on claims for purchase reimbursement, accounting for 27 percent of the total reimbursement for purchase, were in excess of \$100.

Regulations in effect at the time the data presented herein were developed only provided for lump-sum payments for purchases of inexpensive items, those having an allowed charge of less than \$50. Therefore it is not surprising that the bulk of purchase reimbursements is found under \$50. Larger payments could take place on purchases only if the items rented for larger monthly amounts. But, the proportion of rental reimbursements under \$50 is even greater than the purchases. Therefore, administrative waivers in special circumstances or the accumulation of claims before submittal by beneficiaries and suppliers are presumed to have allowed for larger payments in these cases. Of particular interest is the increase in monetary value associated with purchase claims in excess of \$450. These few claims accounted for some 6.6% of the purchase reimbursements. Certainly some extra-ordinary circumstance allowed for these payments prior to the implementation of regulations by the Medicare program which allowed for lump-sum payments up to \$600.

Amounts Paid for Rental and Purchase of DME

For purposes of data presentation, the classification methodology used to aggregate and coordinate DME reimbursement data was altered slightly to illustrate several important ramifications of the use of DME by Medicare beneficiaries.

The following category descriptions are used:

1. Hospital beds and accessories
2. Commode chairs, bedpans, urinals and toilet accessories
3. Canes, crutches and accessories
4. Traction equipment and accessories
5. Walkers and walking aids
6. Wheelchairs and accessories
7. Oxygen
8. Pads and cushions
9. Miscellaneous DME
10. Oxygen therapy equipment
11. Repair/Maintenance
12. Unspecified DME

Although ten of the categories are fairly obvious as to their constituent items, two may need some clarification. The Miscellaneous DME category contains items of DME which are readily identifiable in the records of the carriers as specific items of DME. Each item in the category carries with it a specific procedure code. The Unspecified DME category, on the other hand, contains items which are all coded with one or just a small number of procedure codes which do not uniquely identify

the DME item. These codes are frequently used for new types of DME or in cases in which no charge screens exist for a particular item. It should be noted that there is no way in which the computerized record in this case can be used to determine the types of items in this category.

Tables V - 17 and V - 18 present reimbursement data for 1976 and 1977 for the carriers by these major categories. The amounts shown may be considered maximal amounts paid for DME. These amounts were derived by simply calculating the Medicare portion (80%) of the allowed charge for each DME item or tabulating the amount actually paid in the cases in which this information is included in the computer record of the claim. The inherent assumption is that no deductible amounts were applied to DME.

The data are complete for all five carriers for the year 1976; however, for 1977 data are not included from the Equitable Life Assurance Society Tennessee site and, data from Washington Physicians Service cover only the period January 1, 1977 through October 31, 1977, as the experimental reimbursement mechanisms were implemented at that time. These tabulations constitute an up-date from previous Interim Reports as the database from which they were derived has been fully edited by obtaining further documentation from the carriers.

APPENDIX B provides the detailed data on which these tabulations were based. It should be noted that in the Appendix tables amounts are shown for the rental of oxygen. These are included in the raw data tables in this manner as the claims are processed monthly according to computerized systems which do not

TABLE V - 17:

DME Rental and Purchase Reimbursement Expenditures by Major CategoryAll Participating Carriers (1976)

CATEGORY DESCRIPTION	RENTAL		PURCHASE	
	DOLLARS	PERCENT	DOLLARS	PERCENT
Hospital Beds and Accessories	1,591,925	26.53	520,023	9.85
Commode Chairs, Bedpans, Urinals, and Toilet Accessories	232,862	3.88	158,948	3.01
Canes, Crutches, and Accessories	31,149	0.52	31,656	0.60
Traction Equipment and Accessories	175,114	2.92	77,044	1.46
Walkers and Walking Aids	202,821	3.38	170,110	3.22
Wheelchairs and Accessories	1,091,624	18.19	536,966	10.17
Oxygen	---	0.0	2,598,333	49.21
Pads and Cushions	147,831	2.46	25,911	0.49
Miscellaneous DME	16,570	0.28	18,077	0.34
Oxygen Therapy Equipment	1,963,170	32.72	816,872	15.47
Repair/Maintenance	347,758	5.80	40,611	0.77
Unspecified DME	199,920	3.33	285,558	5.41
TOTAL	6,000,744	100.01	5,280,109	100.00

TABLE V - 18:

DME Rental and Purchase Reimbursement Expenditures by Major CategoryAll Participating Carriers (1977)*

CATEGORY DESCRIPTION	RENTAL		PURCHASE	
	DOLLARS	PERCENT	DOLLARS	PERCENT
Hospital Beds and Accessories	798,338	19.43	867,895	13.81
Commode Chairs, Bedpans, Urinals, and Toilet Accessories	148,765	3.62	218,369	3.47
Canes, Crutches, and Accessories	33,919	0.83	24,887	0.40
Traction Equipment and Accessories	75,780	1.84	108,429	1.73
Walkers and Walking Aids	151,566	3.69	172,573	2.75
Wheelchairs and Accessories	736,903	17.93	644,866	10.26
Oxygen	---	0.00	2,323,585	36.98
Pads and Cushions	45,628	1.11	91,427	1.45
Miscellaneous DME	188,614	4.59	19,450	0.31
Oxygen Therapy Equipment	1,183,791	28.81	1,349,534	21.48
Repair/Maintenance	344,094	8.38	36,201	0.58
Unspecified DME	401,552	9.77	426,464	6.79
TOTAL	4,108,950	100.00	6,283,680	100.01

* Data not included from Equitable Tennessee for 1977 or from
Washington Physicians Service from November 1 through December 31, 1977.

necessarily distinguish rental from purchase of oxygen. However, oxygen is not rented by beneficiaries.

Comments Concerning the Tabulations

In the past, it was generally thought that almost all of the cost of the DME portion of Part B was made up of reimbursement for items such as wheelchairs, hospital beds, commodes, walkers and other types of equipment which are not considered life-support items. These tabulations indicate the magnitude of expenditures for oxygen, oxygen therapy equipment and related items. For all carriers, a sizable portion of the DME dollar is spent on these types of life-support systems. The implications of these findings are certainly far-reaching with regard to reimbursement policies for DME.

For example, consider the acquisition of oxygen by beneficiaries. This normally occurs in one of two ways: either the beneficiary purchases a DOT approved tank and has it refilled by a local oxygen supplier should one exist, or the beneficiary purchases oxygen from a more typical DME supplier (who may or may not have the facilities to refill the tank) and pays only for the oxygen and a handling charge known as demurrage for each and every tank delivered. The demurrage charge may be a one-time per tank charge or it may be synonymous with the rental of the tank. In either event, the oxygen contents are obviously not available for rental. In addition, the marketplace distribution network of oxygen suppliers is typically regional rather than local with the tanks being the property of the oxygen manufacturer. The tanks are distributed to local suppliers and representatives of the manufacturer and then "loaned" for the duration of the use of their contents to retail customer or beneficiary.

Oxygen therapy equipment also presents some unique problems from the standpoint of availability for rental or purchase. Because of existing state laws, regulations and liability insurance coverage considerations, some equipment used locally is owned by a national manufacturer, leased to local dealers and then only available for rental to beneficiaries. This practice is becoming more prevalent as the cost of liability coverage to the local dealer is increasing or is unavailable. In other states some types of oxygen therapy equipment are only available for purchase with the requirement that the customer take part in a training session on its use and service characteristics. Both of these situations combine to prohibit the development of national policies relating to reimbursement for these types of items should these policies require either purchase or rental. Thus, consideration of these local issues is of paramount importance to avoid promulgation of regulations that might effectively make it impossible for some beneficiaries to obtain the needed life-support apparatus and then receive appropriate reimbursement from Medicare.

It was expected that regional and local differences would occur with respect to the rental and purchase of DME. These differences have been thought to be due to many variables in the structure of the DME marketplace as well as differing socioeconomic characteristics and folkways of the beneficiaries. These differences might also be contributed to by differing medical treatment regimens. Although the tabulations presented here provide some insight into the distribution of rentals versus purchases within the major category classifications provided, no causes for these differences between service areas were investigated during the course of the project.

Of note also are the amounts paid either for rentals or purchases which out of necessity at the present are classified as Unspecified. Although constituting a relatively small proportion of the cost of DME to the Government, the argument might be made that these items be more specifically classified in the records of the Beneficiary History Files. It is interesting to note that the amounts related to these Unspecified charges vary significantly from one carrier to another, presumably as a function of the complexity and completeness of the procedure code systems of the carriers, although this conclusion is open to some debate.

Rental Versus Purchase Reimbursement

The data collected during the course of the project indicate that the program is fairly stable relative to the distribution of reimbursement for given categories of equipment. However, the proportion of rental and purchase reimbursement for the two years studied varies considerably. Earlier, it had been thought that this ratio was quite stable, but further clarification of items in the database indicate that for 1976, 53% of the dollars were reimbursed for rentals and the remaining 47% was for purchases. In 1977, the proportion of rental reimbursement dropped to 40% and purchases (which seem to have been greatly influenced by oxygen purchases) rose to 60%. Again, this is based on the raw data contained in APPENDIX B which must be restructured slightly from reporting processing information to reporting actual rentals and sales.

Estimates of Annual Reimbursement for DME Nationally

Based on the total amount reimbursed by the participating carriers in 1976 (\$11,280,853) and recalling that these carriers represent 15.2 percent of the beneficiaries, it could be argued that a reasonable estimate of the total national reimbursement for DME in 1976 was approximately \$72 million. For 1977, consideration must be made of the incomplete data from the two sites which reduces the beneficiary population from which the data relate to 11.6% of the universe of Part B beneficiaries. When combined with the amount reimbursed by the carriers in 1977 (\$10,392,630) an estimate of the total national reimbursement for DME of about \$89 million results.

These estimates are based on all the available data from the sites of the participating carriers, however, if estimates were constructed based on the data from each carrier separately or each carrier service area separately quite a range in values would be seen. Previous reports indicated that the range of estimates for 1976 was from \$50 million to \$134 million and for 1977 from \$73 million to \$130 million. Certainly there are many reasons for a wide range of estimates of expenditures based on data from those carriers who were participants in this study. First and foremost, the carriers were not chosen as a statistical sample of the available carriers, but rather were solicited by the contractor to cooperate voluntarily. To the extent that the beneficiaries served by these carriers are either representative or not of the national experience, these estimates will likewise be representative or not.

Duration of Rentals

Tabulations have been made of several basic statistics which relate to the duration of rental episodes. These tabulations are included in APPENDIX E. They include, the number of episodes of a given duration (with appropriate percentages and cumulative percentages), the number of months in which reimbursement is made for rentals of a given duration, i.e. rental-months (with appropriate percentages and cumulative percentages. From these tabulations the average length of rentals may be calculated. Table V - 19 shows the average length of rental for the five carriers and an overall average for the five carriers.

TABLE V - 19:

Average Length of Rental Episodes

<u>Participating Carrier</u>	<u>Number of Months of Rental Per Episode</u>
Equitable Life Assurance Society	4.88
Group Health Incorporated	5.16
Occidental Life of California	2.88
Travelers Insurance Company	4.91
Washington Physicians Service	3.89
Total For All Participating Carriers	4.29

Several important facets of the rental portion of the DME program are readily apparent from inspection of the tabulations in APPENDIX E. First, the rental experience in terms of duration is vastly different from one geographic area to another. It is also apparent that in many cases individual rentals are relatively short (the majority appear to be of a duration that would not argue for purchase) however, when consideration of the number of months involved in the longer rentals is made, a different picture is seen. Here the aggregate number of months and consequently monthly payments by the Government and the beneficiaries amount to a significant proportion of the total. The data indicate that rentals of one year or less duration accounted for some 85% of the reimbursement expenditures for rental. This was true despite the fact that this group of rentals constituted some 92% of the total number of episodes.

Cost of Extended Rentals

The data made available during this project provide the baseline with which to characterize the DME portion of the Medicare Part B program. In summary, it is estimated that program reimbursement for the two year period 1976 - 1977 was approximately \$161 million dollars. Roughly half of this total was spent on rental reimbursement, the other half on purchase reimbursement. Of the portion spent for purchase reimbursement almost half was for the purchase of oxygen, the other half was for items of DME.

The General Accounting Office, Congress and HCFA interest has continually focused on the extended rental as a source for program savings. If extended rentals are conservatively defined as those of more than a year's duration, then approximately 15% of the annual rental portion of reimbursements or about \$12 million might be considered available for savings. However, great care must be given to estimating savings that could accrue to the program if reimbursement procedures were changed.

A significant factor involved in this determination is the state of knowledge of the length of medical necessity for an item of DME. Often statements such as indefinite or indeterminate are made. Given this lack of certainty concerning the length of time an equipment item might be needed, the beneficiary is at a loss to determine whether it would be prudent to purchase or rent the item. Consequently, rental is frequently chosen. In some cases, in fact in the vast majority, the rental episode ends fairly soon and the beneficiary has chosen the most economical method for obtaining the needed equipment by default.

Experimental Data

Data are presented here which reflect the experience of Washington Physicians Service both before and after the implementation of the experimental alternatives. These tabulations serve to present a broad picture of the distribution of rental and purchase reimbursement. Table V - 20 indicates the percentage distribution of DME reimbursements made in Washington prior to the experiment. Both rentals and purchases are shown. At that time rental accounted for about 41% of total reimbursements. During the experimental period rental accounted for approximately 42%, a slight increase.

Both tables indicate that the vast majority of DME being rented is either hospital beds, wheelchairs or oxygen therapy equipment. The mix of claims for these items did, however, change after the experiment. On the purchase side, it can be seen that subsequent to the implementation of the experiment, more purchase reimbursement is accounted for by equipment items rather than oxygen. In particular, hospital beds and wheelchairs seem to have become more accessible for purchase.

In addition to the above, prior to the experiment, some 2% of the rental episodes of more than a year's duration accounted for 11% of rental reimbursement. During the experiment those figures changed to 1% of the episodes accounting for only 4% of rental reimbursement.

Consultation with the carrier led to the following observations regarding the experimental reimbursement procedures. Whereas prior to the experiment, there existed an inventory of claims on which monthly installment payments were being made as reimbursement for purchases, following the introduction of the lump-sum provisions this claim load was reduced to virtually nothing. Clearly the provision of lump-sum payments for those beneficiaries who have an indication of long-term medical necessity and who choose to purchase DME has had an effect on this one aspect of the claims processing operation. Roughly 10% of the claims volume during the experiment was for purchases of new equipment for which the period of medical necessity was long enough to allow for lump-sum payment. Another 30% of the volume was for ordinary rentals which appeared as new claims each month. The remainder was made up of claims for oxygen. Less than 1% of the claims were for used equipment and no rental/purchase conversions were ever reimbursed.

In summary, it would appear that the experimental lump-sum alternatives provided, either singly or in concert with other market conditions, a movement towards the purchase of some items of durable medical equipment which have traditionally been rented.

TABLE V - 20:

Percent DME Rental and Purchase Reimbursement by Major CategoryWashington Physicians Service (1976 - October 31, 1977)

CATEGORY DESCRIPTION	PERCENT OF RENTAL	PERCENT OF PURCHASE
Hospital Beds and Accessories	15.76	3.71
Commode Chairs, Bedpans, Urinals, and Toilet Accessories	3.21	1.59
Canes, Crutches, and Accessories	0.73	0.60
Traction Equipment and Accessories	1.41	1.16
Walkers and Walking Aids	4.23	2.30
Wheelchairs and Accessories	16.79	7.81
Oxygen	0.00	65.71
Pads and Cushions	0.30	0.18
Miscellaneous DME	8.61	0.61
Oxygen Therapy Equipment	47.53	13.92
Repair/Maintenance	0.18	0.08
Unspecified DME	1.25	2.33
TOTAL	100.00	100.00

TABLE V - 21:

Percent DME Rental and Purchase Reimbursement by Major CategoryWashington Physicians Service (November 1, 1977 - July 1, 1979)

CATEGORY DESCRIPTION	PERCENT OF RENTAL	PERCENT OF PURCHASE
Hospital Beds and Accessories	33.12	6.69
Commode Chairs, Bedpans, Urinals, and Toilet Accessories	1.72	1.51
Canes, Crutches, and Accessories	0.69	0.40
Traction Equipment and Accessories	1.19	1.84
Walkers and Walking Aids	4.24	2.38
Wheelchairs and Accessories	17.56	10.20
Oxygen	0.00	53.28
Pads and Cushions	0.44	0.41
Miscellaneous DME	8.13	4.45
Oxygen Therapy Equipment	31.70	15.85
Repair/Maintenance	1.19	2.99
Unspecified DME	0.02	0.00
TOTAL	100.00	100.00

Administrative Costs

One thrust of the project was to examine administrative costs incurred by the carriers for processing DME claims. It was discovered that, in general, organizational and procedural arrangements for handling DME claims varied from carrier to carrier. Additionally, it was found that no separate data were available for the administrative costs associated with processing DME claims, either in the offices of the carriers or HCFA.

The variety of procedures followed by the carriers for DME claims was unusually complex. Illustrations may be cited as follows: One carrier, for example, utilized a group of central processing personnel for DME claims. These personnel either had special training for the field or developed a good knowledge of it through extensive experience on the job. Almost invariably these were more senior personnel than those handling other Part B claims. Even in this arrangement, however, the DME unit still relied upon a central office computer to access information concerning allowed charges. At the other extreme, was a carrier where all personnel handled all types of Part B claims, including DME. In this instance there was a high degree of automation with respect to a variety of decision-making criteria essential for reimbursement determination. Between these two extremes were carriers which utilized either a group or individual, highly experienced in DME but at the same time, relied on support from other groups within the organization for such activities as correspondence, telephone contacts, exception processing and the like. Consequently, to develop comprehen-

sive national data as to the total costs incurred to administer DME reimbursements, a specialized, through-going, methodology which would take into account appropriate cost allocation methods would have to be devised and applied on a carrier-by-carrier basis for all carriers.

As can be seen by implication from the above, no specific data on DME and costs as such were found, either for any one carrier or for the carrier population as a whole. It should be pointed out that administrative cost data for Part B are contained in regular carrier reports to HCFA. These are summarized and published by the Government. However, as indicated above, there is no breakdown as between costs allowable to DME and those allowable to other Part B claims.

Some indication of the possible magnitude of DME claims processing costs was obtained through extensive discussion with the carriers participating in the project and all others who were visited. Despite the lack of precise information there seemed to be a consensus that the processing of DME claims required 2-1/2 to 3-1-2 times as much effort as that for other claims under Part B. Indications of this cost may be found in oral reports given the project team that the number of claims handled per day by DME processors was less than half that for the others. These reports quite probably err on the conservative side since some functions were allocated to other organizational components. Many DME claims also require consideration of several reimbursement alternatives (rental, lease, purchase, etc.) which is not a consideration with respect to reimbursement for claims for physicians services. Finally, the participants in the provision of DME, as

contrasted with other Part B covered services, involve an additional party, namely, the supplier, with whom there is extensive contact in settling a claim.

CHAPTER VI

IMPLICATIONS

INTRODUCTION

The purpose of this DME project was to conduct an experiment as authorized by the Congress and in accordance with the terms laid down by the Health Care Financing Administration. As a result, the contractor's team (particularly the Project Manager and the Principal Investigator) undertook a wide variety of activities. During the course of the project, visits were made to many Part B carriers, Part A intermediaries and State Medicaid officials. Conferences of supplier organizations were attended by staff and on several occasions staff were invited speakers at these meetings. Information was obtained from members of an Advisory Panel established specifically for the experiment. Consultants were retained with specific experience relating to DME to assist the project team. Meetings were held with HCFA Central Office and Regional Office staff continuously during the course of the work. Meetings were also held with Congressional staff personnel concerning many aspects of the experiment, and the course of DME legislation and hearings was followed with care.

Data were developed during the project, primarily in response to the Congressional mandate for the experiment as articulated by the Scope of Work provided to the contractor by HCFA. Consequently, the project as a whole was subject to a number of limitations, for example, interviews were not conducted

with individual beneficiaries or individual physicians. Initial claims submitted for reimbursement by suppliers or beneficiaries were not examined; rather, resulting payment records were analyzed. The decision-making considerations regarding procurement or provision of DME by beneficiaries, physicians or suppliers were not investigated. The consequence of these limitations is that there are large areas where the project team can only surmise the character of these factors. A number of areas have been identified, therefore, in which additional research may be required.

As a result of the activities described above and analysis of the data, Exotech Research & Analysis, Inc. (ER&A) developed a number of impressions and insights into the field of DME as a whole. The project team sees a variety of implications affecting provision and reimbursement for DME as viewed from the perspective of this project over a period from Protocol development to completion of the experiment. These implications follow.

IMPLICATIONS

1. Greater attention should be given to DME by HCFA. For the first time, this study has provided quantitative data relating to reimbursement for DME. The amounts for DME reimbursement are much larger than generally thought in the past. In addition, the administrative effort and cost associated with DME claims was reported to be several times that of other claims handled by the carriers.

The field of DME provision is also complex, more so than realized in the past. Timing, availability of equipment, supplier involvement in the provision of health care and the interaction among the prescribing physician, the beneficiary or his/her representatives, supplier, carrier and the State and the Federal Government are all operating factors in the DME system.

Moreover, there is a vast array of equipment for which reimbursement is made under HCFA programs. Experience with claims for equipment has led the Part B carriers to develop classification schemes or procedure code systems for DME that reflect the experience in each of their service areas. As a consequence, all these systems are different.

An important finding of the study was that approximately one half of Part B program expenditures for DME involves oxygen gas and oxygen therapy equipment. Consequently it appears that particular attention should be given to this segment of the program. Adequate delivery and availability of this type of life-support equipment may be critical to the immediate health needs of the beneficiary. Unique problems with respect to training, service, maintenance, operation and availability of equipment for either rental or sale complicate the transaction for this type of DME and require special consideration. Since this is life-support apparatus, it has some of the characteristics of dialysis equipment, for which there are separate provisions, particularly in terms of reimbursement and coverage.

2. As indicated above, the carriers have developed different classification methodologies for DME based on their experience with claims in their particular service areas. These schemes vary widely in the number of categories utilized to classify DME. They may classify as few as forty or as many as two hundred and fifty different items of DME. The classification schemes become the basis for reasonable charge calculations as well as reimbursement. Insofar as they are quite different from carrier to carrier, comparative analysis of reimbursement data by type of DME among carriers becomes very difficult. One major subtask undertaken by the project team was the development of a method by which the various procedure code systems could be integrated. Other implications concerning these differing schemes are noted throughout this section.

3. In light of the diversity of classification schemes utilized by the carriers, thought should be given to a uniform classification methodology to be used by all carriers nationally. HCFA Central Office should be responsible for leading the development of this scheme with the assistance of the Regional Offices, the Part B carriers, state representatives of the Medicaid program, the supplier community and physicians who are specialized in the prescription of DME and inhalation and respiratory therapy. The classification methodology should be reviewed and updated annually to reflect the introduction of new technology and new items of equipment into the marketplace.

Activities are under way within HCFA toward this end at present. However, other government agencies, including the Food and Drug Administration, which has

responsibility for the Medical Device Amendments, the Veterans Administration, which sets standards for equipment in such areas as procurement, fitting and construction, and the Department of Commerce, which maintains the Standard Industrial Classification codes for industries and products, should be consulted, as a minimum, in defining such a national classification scheme.

4. Based on analyses of large-scale data, this research bears out some of the findings of the 1972 General Accounting Office Report. Notably, the existence of extended or prolonged rentals in approximately the proportion found by GAO in its analysis of data for 1970 was also found in the analysis of data for the period 1976-1977. Factors inhibiting purchase of DME seem also to be substantially the same as earlier. Another area in which corroborative evidence of GAO findings was found was the proportion of beneficiaries who use DME. Only a small percentage of Part B beneficiaries was found to have filed claims for DME during the period studied.

One finding which differs sharply from the GAO report is the proportion of rental reimbursement to purchase reimbursement. GAO found that reimbursements were about 82 percent for rentals and 18 percent for purchases. This study found roughly a fifty-fifty split between rental and purchase reimbursement.

5. The USED equipment and RENTAL/PURCHASE alternatives offered in the experiment did not result in acceptance by beneficiaries. Although the reasons are

not known, it is surmised that they may be numerous, including the motivations and attitudes of the beneficiary at the time the DME was needed, supplier acceptance and promotion of the alternatives and physician understanding and participation in the decision-making process.

Non-use of these alternatives occurred despite a public information campaign mounted at the outset of the implementation of the experiment which included mailings to all beneficiaries, suppliers and physicians in the carrier service area; and, in addition, meetings were held with suppliers to outline the alternatives and explain the new procedures. Following this campaign, numerous telephone inquiries were responded to by the carrier relating to the experimental effort. Since these alternatives still seem sensible and were initially proposed by Congress, additional research might be contemplated to find out why they were not utilized. This might be especially helpful since legislation has now been enacted to provide the same incentives for used equipment nationally. Clearly, based on the experience in the experimental area, other methods and procedures need to be developed in the future to encourage and promote use of these economical alternatives.

6. LEASE-PURCHASE, as an alternative, one also recently provided for by Congress, deserves discussion. This method involves an obligation for the period of the lease. The implications are that: the period of need for the equipment is not necessarily known in advance and the payment method must have flexibility to respond to the economic consequences of a period of medical necessity of

unknown length. Lease-purchase will result in less cost when compared with an outright purchase only if the beneficiary dies, recovers or no longer requires the equipment prior to the occurrence of purchase. In cases of established long-term need, outright purchase is clearly less costly.

Due to many factors, not the least of which may be the beneficiary's unwillingness to enter into a lease for equipment and therefore a financial liability based on an uncertain period of medical necessity, leasing may be an inappropriate commercial arrangement for beneficiaries of HCFA programs. In addition, due to other factors, including Federal Truth in Leasing Laws and their attendant requirements for warranty provisions by the Lessor, no industry that supports or enters into leasing arrangements for DME with individual consumers seems to exist in the United States. The question of transfer of title, discussed below, also arises. For these reasons, leasing may not be a feasible reimbursement alternative and provision for it should be reconsidered by Congress and HCFA.

7. Recent DME legislation also provides that beneficiaries should be required to purchase, rather than rent equipment, under stated conditions. However, such mandatory purchase must be evaluated in light of the requirement that the beneficiary fund the transaction at that time. Purchase may place a severe financial burden on the beneficiary. Consequently, some method to alleviate this burden should be developed.

Although some suppliers of DME will arrange for time payments for purchase,

others will not do so. Many of the latter may be small businesses which cannot support such extensions of credit. If the supplier accepts assignment, the problem for the beneficiary is reduced. However, this may give rise to complications for the supplier. One of these may result from transfer of title in a sale and the subsequent problem of recovery of equipment if the claim is denied. Another is that the level of reimbursement may be less than anticipated by the supplier. The third is the problem of obtaining payment from the beneficiary for the deductible, if applicable, and for the co-insurance. All of these places an undue financial risk on the supplier. As a result of such complications, suppliers are loathe to take assignment for equipment sales.

Notwithstanding the above problems, assignment rates were found to be relatively high, both for rental and for purchase. However, rate of assignment for purchases, as found in the research, was heavily weighted by sales of oxygen gas, implying that assignment rates for equipment items were lower.

8. As noted above, oxygen gas and life-support equipment constitute a large proportion of reimbursement for DME. The project discovered that almost one fourth of all DME dollar reimbursement is for oxygen gas, which is a consumable, but falls into the DME category because of its related equipment dispensing system. The timely availability of such equipment and supplies has great urgency with respect to the health and well-being of the beneficiary. Care must be taken in devising administrative procedures for reimbursement for such equipment so as

not to affect the timeliness and availability of needed oxygen equipment and supplies.

More specifically, provision of oxygen to an ailing beneficiary should not be hindered by economic considerations, such as a requirement for an initial large monetary outlay which may be beyond the financial capability of the patient.

On the other side of the coin, it should be pointed out that other studies have shown that oxygen may be over-utilized. However, this is a medical subject beyond the scope of this project.

9. The supplier industry takes the position that there are costly repair, timeliness, support, maintenance, inventory, fitting, trouble-shooting, delivery, set-up, etc. services which are necessarily reflected in rates charged for rental and sale of DME. In a practical everyday sense, as seen from the standpoint of the beneficiary, these services may be entirely realistic requirements. However, studies are needed to determine the full range of such services actually required to meet beneficiary needs. These studies would be operational in character, would track the flow of such activities and determine the extent to which they are in the interest of the beneficiary. Such studies should include the needs and services as seen from the viewpoints of the beneficiaries, physicians and suppliers. The results of such studies would provide a better understanding of the role of suppliers in providing DME to the beneficiary community.

10. In meetings with suppliers and organizations of suppliers it became evident that a major concern on the part of this industry relates to the timeliness with which the Customary and Prevailing Charges are updated to reflect current pricing. During the period of the project, inflationary pressures on suppliers for capital equipment (the price of which is set by manufacturers) have been cited as a primary reason for the need to provide more frequent or current Reasonable Charges.

This would imply that the current process of establishing these charges on an historical basis would have to be carried out more frequently. A precedent for doing this for DME as a whole may be found in the present practice for Lowest Charge Level provisions for a standard hospital bed and a standard wheelchair, which are updated semi-annually. On the other hand, and from the standpoint of the Part B program, such a procedure if applied to DME as a whole would, of course, result in higher administrative costs. This consideration alone could possibly rule out such a procedure.

Another factor militating against more frequent updating may be the nature of the process for making the necessary determinations. The primary function of the carrier is to process claims and make reimbursements. The updating activity is different in character from these ongoing claims processing operations and requires specialized, intensive effort. This effort is complex and time-consuming and results in development of charge levels to be used until the next update. The activity absorbs available computer and personnel time to such an extent that delays result in claims processing operations. Delays in the update also sometimes

create the basis for appeals as to allowable reimbursement and a further drain on carrier administrative resources. The importance of this effort is underscored by an HCFA requirement that updated files be approved by Regional Offices prior to implementation.

11. Further study of all system costs as they relate to development and maintenance of the Customary and Prevailing Charges needs to be undertaken to determine whether this technique is cost-effective to the Government. It is well known that these procedures are both costly and time-consuming to the carrier and require attention from the Regional Offices as noted above.

The basis of the reasonable charge procedure is found in Medicare legislation. Consequently, the present cumbersome procedures result from compliance with the law. Should the Congress determine that a different procedure is required, it may be necessary to provide legislation identifying in detail the steps to be followed.

Alternatively, totally different and simpler techniques for determining amounts to be paid for DME can be found in jurisdictions under the Medicaid portion of HCFA programs. For example, in one state, reimbursement is based on the cost of the equipment to the supplier (substantiated by invoices) plus a standard percentage mark-up. In another state, oxygen and some related equipment is purchased as a result of competitive bidding. In still another state, competitive bidding is utilized to establish prices for some other items. Techniques such as these are obviously

less cumbersome than the current Medicare procedures. These techniques require evaluation to determine whether they are appropriate for the Federal program as a whole.

12. Thought has been given by some to the possibility of updating the Customary and Prevailing Charges for DME by means of linkage to a national economic index of some type. No simple method for doing so has evolved. For example, although physician reimbursements have been tied to an economic index, a similar procedure would not necessarily be appropriate for DME. For physicians, the largest component of the charges is for personal services. In contrast, for suppliers, it is only partly so, the other part being the rising cost of the equipment purchased from manufacturers, rising costs for trucks and rapid increases in the price of gasoline. Further study of the possibility of some type of linkage to a national economic index or combination of indices may be warranted in an effort to simplify the updating process.

13. Still another aspect of the reasonable charge concept deserves mention. A mounting body of literature concerning the economic consequences or the impact of the reasonable charge methodology is concluding that perhaps it should be replaced with some alternative that is less inflationary and more fair. Although this study did not attempt to investigate these issues in a research sense, possible alternatives to the reasonable charge process were found, particularly in the state Medicaid programs.

As indicated by GAO in 1972, solutions to the overall set of problems which are confronted in providing insurance benefits for DME by the Government might have to be regional or local in character in order that inconsistencies with State laws and programs do not prove counterproductive. Although HCFA has responsibility for both Medicare and Medicaid, the philosophy, operation and program clients may be different from area to area. These differences have led the states to develop radically different methods for providing DME or reimbursement for DME over the last twelve years. Virtually any reimbursement alternative that can be devised has been used by one state or another during this time. Their experience should be documented and studied to determine the efficacy of implementing tested alternatives that have already been used in other than national jurisdictions.

14. The complex reasoning and decision-making undertaken by physicians in prescribing DME for use in the home is another area in which little is known. This study did not attempt to determine physician requirements for DME home use or factors which enter into the estimation of the length of medical necessity. Certainly the latter factor can be seen to be the single most important determinant of prudent rent versus purchase decisions.

The available data indicate that the vast majority of reimbursements taken as a whole are for relatively short periods of rental. However, the reasons are not known. No information is available as to whether the patient recovered or obtained care in a setting different from his own home. Nor are data available

which shed light on whether beneficiaries continued to have a valid medical necessity after a purchase transaction occurred. In the latter cases, presumably the estimated period of medical necessity was sufficient to warrant purchase and the actual term of need was long enough to support that decision.

Under current legislation, the Secretary (of DHEW) is required to make decisions as to whether beneficiaries should rent or purchase DME. The Secretary is dependent on prescriptions by physicians with respect to individual patients. Studies should be performed as to the estimated period of medical necessity as stated by physicians in comparison with the actual term of need for DME by patients as demonstrated over periods of utilization of the DME.

15. Given the prevalence of oxygen and oxygen therapy equipment in the Part B program, it is entirely conceivable that procedures applicable to reimbursement of more typical items of DME are not necessarily applicable to this type of life-support equipment and supplies. The structure of the industry that provides oxygen to consumers in the U. S. is quite different organizationally from that of the typical DME supplier. Further study should be undertaken to determine both the economic and organizational structure of this unique segment of the health care industry to determine the methods by which beneficiaries are supplied with both the equipment and the oxygen gas. The purpose of this effort would be to identify whether there are characteristics involved that require different solutions than those which may be used for reimbursement of other items of DME.

16. Another possible division of DME items for the purpose of reimbursement involves the specification of certain items for which reimbursement would be permitted either as rental-only or purchase-only items. Equipment could be categorized for rental-only if monetary considerations or factors of complexity in operation or service were thought to preclude purchase of the items by beneficiaries. This might be true of some types of life-support equipment. On the other hand, certain equipment items which are either inexpensive or do not require a significant amount of service or skill to use could be included in reimbursement only for purchase. However, requirements for operation and service would have to be developed and studies would have to be undertaken so that classification of equipment into either the rental-only or purchase-only category could realistically be made.

In addition, the implication of such a procedure on the supplier industry should also be taken into account. For example, the possibility that rental of inexpensive items of DME may be subsidizing higher cost items, as suggested by some observers, should be evaluated.

17. One surprising finding was the large volume of purchase reimbursement under the Part B program. As indicated earlier, the GAO study in 1972 found that about 82 percent of reimbursement was for rentals and 18 percent was for purchases. This study found an almost even mix of rental and purchase reimbursement dollars.

However, extended or prolonged rentals still exist. It must be remembered that originally the program allowed only for rental. Subsequently, additional legislation allowed reimbursement for purchases; in retrospect, however, purchases were not promoted to any great extent by the regulations in cases where their use might have been more economical to either the Government or the beneficiary. In short, until recently, the purchase concept was not embraced by either the Government, the beneficiaries or the suppliers of DME.

In 1977 though, Section 16 of P. L. 95-142 provided that the Secretary of DHEW, rather than the beneficiary, make these rent versus purchase decisions. The project team feels that the development and implementation of regulations promulgated under these provisions should be followed carefully by HCFA to determine if their impact on the beneficiary and the program in general is "desirable" (as defined by legislation) and provides appropriate access to care by them.

18. In the interest of the program, more information should be made available to beneficiaries, physicians and suppliers as to the specific types of equipment for which reimbursement is available. If the uniform national classification scheme referred to above were forthcoming, copies could be distributed to serve this purpose. This would eliminate claims submitted in ignorance of the benefits which are allowed under the program.

GAO indicated in 1972 that beneficiaries often did not know of the option to

purchase DME since the program had originally allowed only for rental reimbursement. Experience during the experiment indicated that not only did beneficiaries not know or understand the reimbursement procedures under Medicare, but they were not aware of the types of DME available to them for reimbursement.

19. Not only should the program advertise the equipment for which benefits are paid under the program, but it should also make public the amounts generally reimbursable by item. Rather than having the beneficiaries of the program choose reimbursement alternatives out of ignorance of the financial consequences, assistance should be provided to them so that reasonable and economically rational decisions may be made. In the absence of information regarding reimbursement it is unlikely that a prudent decision will be made. Under the current system, prevailing charge information is available and should be provided to each beneficiary, supplier and physician.

20. Durable medical equipment assists the beneficiary to cope with a physical condition in a home environment. Physicians release patients from the hospital with prescriptions for DME as appropriate. It has been conjectured that greater understanding and utilization of DME might have the effect of shortening hospital stays. Hospital costs nationally are substantial and represent the largest segment of HCFA expenditures. Thus, the question may be raised as to whether DME use in the home could substitute for institutional care at an earlier point than may be current practice. A one-week hospital stay incurs costs which, if they could be

obviated, would provide for rental or purchase of a substantial quantity of possibly lower-cost DME. Research into this possibility is recommended.

21. It is not generally realized that there is a substantial difference between the actual charge for DME made to the beneficiary and the amount received as reimbursement. That is, Medicare provides about 60 percent of the submitted charge of those claims accepted for reimbursement. Reasonable charge reductions account for about 18 percent. Deductible and co-insurance payments account for about 7 percent and 15 percent respectively. Stated another way, it can be seen that the beneficiary must arrange to pay 40 percent of the cost of DME on the average.

If research demonstrates that use of DME in the home would result in a reduction of overall program costs, the clear implication is that such use should be encouraged in the interest of HCFA programs as a whole. In that case, considering the high cost of hospitalization, HCFA might be inclined to pay a higher proportion or all of the cost of DME.

22. An unusual aspect of the contract for the DME experiment was the provision that voluntary cooperation be obtained from various groups including beneficiaries, physicians, suppliers, supplier organizations and Part B carriers. Consequently, an extensive effort was undertaken to bring this about. With respect to the first four groups, it may be pointed out that the project team

developed public information releases and held extensive conferences with carrier, Regional Office, and Central Office personnel and modified the original drafts to maximize their effectiveness. As pointed out elsewhere, mailings were made to all of these groups.

With respect to carriers, a different procedure for gaining their cooperation prevailed. Carriers throughout the country were contacted and field trips were made to their headquarters and field offices for the purpose of explaining the experiment and soliciting cooperation. Nineteen carriers were contacted whose service areas covered thirty-seven states or parts of states. In some instances, carriers were not contacted upon the advice of HCFA Central and/or Regional Offices who for one reason or another opposed participation by particular carriers. Out of this number only five carriers agreed to participate. The effort to obtain the required cooperation from carriers was extensive and may be considered an "experiment" with respect to the nature of the contract.

The project team believes the effort involved in getting voluntary cooperation of carriers was exorbitant. It is recommended that HCFA follow other procedures in future experiments and demonstration projects. More specifically, such research contracts should contain a provision in which the Government would undertake to ensure cooperation of carriers selected for the purpose of the research.

23. The data show that the vast majority of all rental and purchase reimbursement payments lie in the class interval below \$100 per month. There may be implications in this finding as to ways in which administrative costs regarding such payments may be minimized. In the case of rental and installment-purchase, where monthly payments are made, reimbursements could be automated to cover the period of prescribed medical necessity with some possible savings to the program in administrative costs. The importance of doing this is emphasized by the fact that administrative costs for DME are substantially higher than for other services under HCFA programs.

This possibility was recognized by the Government some years ago and efforts were made to implement such a methodology for the Model B System users. The demise of the HCFA Model B System organization under Congressional mandate is likely to have limited this effort.

Additionally, it may be said, action by the Government to increase the dollar limits for lump-sum payment for purchase should have the result in the future of reducing administrative costs for purchase reimbursement which might, historically, have been made on a monthly basis.

24. As a procedure in the experiment, lump-sum payments for purchases were made with no ceiling. HCFA procedures currently provide a \$600 maximum for such reimbursement. Since lump-sum is a one-time payment, the associated administrative cost is lower than if payments are made each month for a number

of months. In the view of the project team, there appears to be insufficient justification for placing a ceiling on such payments, particularly as weighed against administrative costs for an extended series of monthly payments for purchase. This is particularly true since a stated dollar ceiling would inevitably have to be revised to account for rising costs in the future.

Unless the ceiling for lump-sum payment is eliminated, beneficiaries will be required to make the outlay for purchase of equipment (except in cases of assignment) in advance simply because a given piece of equipment is costly. This situation would be aggravated by the imposition of a purchase requirement by the Secretary of DHEW. These conditions, therefore, also argue for lump-sum payment without a ceiling.

25. The younger, physically disabled population, some covered by HCFA programs, pose a special problem with respect to provision of DME and reimbursement for it. In interviews with state Medicaid personnel, the point was made that amounts authorized for payment under HCFA rules were frequently insufficient, particularly for customized, heavily-used equipment required for this special population. Where the amount authorized for the Medicare/Medicaid reimbursement to cover the total cost and where the beneficiary may be indigent, he/she may effectively be denied purchase or rental of needed equipment.

Research into the needs for specialized and/or costly DME for this younger population group should be undertaken with a view of developing more realistic

reimbursement procedures and levels. Such steps were urged by state officials in the course of this project.

26. During the course of the project it became evident that Part A intermediaries also make substantial reimbursements for DME. However, the policies and procedures used for Part A and Part B DME reimbursements differ.

DME reimbursement under Part A is provided to hospitals and home health agencies on the basis of "reasonable cost" rather than "reasonable charge". Essentially claims are submitted to the Part A intermediaries and 80 percent of each submitted charge is paid. Adjustments may be made at year's end when cost reports are audited. This procedure is in marked contrast to the "reasonable charge" methodology involved under Part B.

Not only do DME reimbursement methods differ, but, in fact, the type of DME provided under Part A may not be specified in the claims documentation. Consequently, the exact volume and nature of DME under Part A is not known. Thus, there is an understatement of DME reimbursements under HCFA programs. A method should be developed to reconcile the coverage, reimbursement and reporting procedures for DME under Part A, Part B and Medicaid portion of HCFA programs so that a better picture of DME can be obtained for these programs as a whole.

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